Section

24

Texas Medicaid (Title XIX) Home Health Services

24.1 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 the Texas Medicaid Program.

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 younger than 21 years of age will be provided by the Texas Health and Human Services Commission (HHSC) under the PCS benefit.

Refer to: "Personal Care Services (THSteps-CCP Only)" on page 43-65.

To provide Texas Health Steps (THSteps)-Comprehensive Care Program (CCP) services, HCSSA providers must follow the enrollment procedures in Section 43.4, "THSteps-Comprehensive Care Program (CCP)."

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 the Texas Medicaid Program.

Providers may obtain the 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

For prior authorization requests on the Home Health Services contact:

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

For general questions, such as claims history information, prior authorization history, procedure codes, procedural matters, or to verify if prior authorization has already been issued, call the TMHP Comprehensive Care Program (CCP)-Home Health Provider Line at 1-800-846-7470.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to the Texas Medicaid Program, it is a violation of Texas Medicaid Program rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to the Texas Medicaid Program, providers can also be subject to Texas Medicaid Program sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Provider Enrollment" on page 1-2 for information about enrollment procedures.

24.1.1 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 in "Enrollment" on page 24-4.

24.1.2 Pending Agency Certification

Home health agencies and DME-Home Health Services (DMEH) suppliers submitting claims before the enrollment process is complete or without authorization for services issued by TMHP Home Health Services 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 TMHP's Home Health Services 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.

Do not submit Home Health Services claims for payment until Medicaid certification is received and a prior authorization number is assigned.

Refer to: "Clinical Laboratory Improvement Amendments (CLIA)" on page 26-2.

24.2 Medicaid Managed Care Enrollment

Certain providers may be required to enroll with a Medicaid Managed Care plan to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.

Refer to: "Medicaid Managed Care" on page 7-4.

24.3 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates calculated in accordance with 1 TAC §355.8021(a).

Fee schedules for all services in this chapter are available on the TMHP website at www.tmhp.com/file library /file library/fee schedules.

A skilled nurse (SN) and/or home health aide (HHA) visit may be provided up to a maximum of 2.5 hours per visit. A combined total of three SN and/or HHA visits may be reimbursed per day.

When services are provided to more than one client in the same setting, only the units directly provided to each client at distinct, separate time periods will be reimbursed. Provider documentation must support the services were delivered at distinct, separate time periods. Total home health services billed for all clients cannot exceed the individual provider's total number of hours spent at the place of service (POS).

One as needed (PRN) SN visit may be reimbursed every 30 days outside of the prior authorized visits when SN visits have been authorized for the particular client.

For reimbursement purposes, Home Health SN and/or HHA services are always billed as POS 2 (home) regardless of the setting in which the services are actually provided. SN and/or HHA services provided in the day care or school setting will not be reimbursed.

All unique procedure codes must be billed according to the description of the procedure code. The quantity billed must be identified and each procedure code must be listed as separate line items on the claim. SN, HHA, physical therapy (PT), and occupational therapy (OT) visits must be billed in 15 minute increments.

Procedural modifiers are required when billing SN, HHA, PT, and OT visits.

Modifier	Visit Service Category
U2	SN or home health aide second visit per day
U3	SN or home health aide third visit per day
GP	PT
GO	OT

Home health agencies are reimbursed for DME and expendable supplies in accordance with 1 TAC §355.8021. The current DME fee schedule is available 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.

TMHP manually prices DME and expendable supplies that have no established fee, other than nutritional products, based on the manufacturer's suggested retail price (MSRP) less 18 percent, with documentation of the MSRP submitted by the provider. If there is no MSRP available, reimbursement is at an established percentage of the provider's invoice cost. Nutritional products that require manual pricing are priced at 89.5 percent of the average wholesale price (AWP). The Texas Medicaid Program 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: "Texas Medicaid Reimbursement" on page 2-1 for more information about reimbursement.

24.3.1 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. Providers who have received previous denials based on homebound criteria need to appeal their claims with appropriate documentation to include a copy of the claim, R&S report, and authorization requests.

The Medicaid client must be eligible on the date(s) of services (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 are considered a benefit under Home Health Services and as documented in the client's plan of care (POC).
- 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 all 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 and signed by the treating physician for these clients.

Refer to: "Automated Inquiry System (AIS)" on page xiii.

Note: *Medicaid beneficiaries who are under 21 years of age are entitled to all medically necessary private duty nursing (PDN) services and/or home health SN services. Nursing services are medically necessary when the requested services are nursing services as defined in the Texas Nursing Practice Act and its implementing regulations; the requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition; and there is no third-party resource that is finan-*

cially responsible for the services. Requests for nursing services must be submitted on the required Medicaid forms and must include supporting documentation. The supporting documentation must clearly and consistently describe the beneficiary's current diagnosis, functional status and condition; consistently describe the treatment throughout the documentation; and provide a sufficient explanation of how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition. Medically necessary nursing services will be authorized either as PDN services or as Home Health SN services, depending on whether the beneficiary's nursing needs can be met on a per visit basis.

24.3.1.1 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.

24.3.1.2 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 authorization for services already rendered.* The agency must contact TMHP Home Health Services Authorization Department to obtain authorization for *current services within three business days of the client's eligibility being added to TMHP's eligibility file*. The nurse who made the initial assessment visit in the client's home should make this call.

24.3.2 Prior Authorization

Prior authorization of initial coverage of home health services (SN, HHA, PT, OT) for an eligible client can be obtained by calling the TMHP Contact Center Home Health Services line at 1-800-925-8957, by fax to 1-512-514-4209 or through the TMHP website at www.tmhp.com.

The following authorization requests can be submitted through 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 (THSteps-CCP/ Home Health Services) (Attachments will be sent separately due to size and detailed information).
- Home Health Services Plan of Care (POC).

Refer to: "Prior Authorization Requests Through the TMHP Website" on page 5-4 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, and Medicare approves the service, and Medicaid is secondary, prior authorization is not required. TMHP will only pay the coinsurance.

If Medicare denied the service, then Medicaid prior authorization is required. Contact Medicaid within 30 days of receipt of Medicare's final denial letter. The final denial letter from Medicare *must* accompany the authorization request.

If the service is a Medicaid-only service, prior authorization is required.

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 TMHP Home Health Services Authorization Department within three business days of the start of care (SOC) for professional services or the DOS for DME/ medical supplies to obtain authorization. Following the registered nurse's (RN) assessment/ evaluation of the client in the home setting, the nurse who made the initial assessment visit in the client's home should 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 is lacking medical necessity, the provider will be requested to furnish additional documentation as required to make a decision on the request. Providers have two weeks to submit the requested documentation because it often must be obtained from the client's physician. If the additional documentation is received within the two-week period, 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, 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's Home Health Services toll-free number is 1-800-925-8957. The Home Health Services Authorization Checklist is a useful resource for home health agency

providers completing the 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: "Durable Medical Equipment (DME) and Supplies" on page 24-29 for DME/ medical supplies prior authorization and "Medicaid Relationship to Medicare" on page 24-70.

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

24.4 Home Health Services

The benefit period for home health professional services is up to 60 days with a current POC. In chronic and stable situations, DME and supplies ordered on a Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form may be *authorized for up to six 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 six months. This extended authorization period begins on the date that clients receive their first authorized home health service. The Texas Medicaid Program allows additional visits, DME, or supplies that have been determined to be medically necessary and have been authorized by TMHP Home Health Services 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.

24.4.1 Client Evaluation

When a home health agency receives a referral to provide home health services, supplies, or DME for a Medicaid-eligible client, the agency-employed RN should evaluate the client in the home before calling TMHP for prior authorization. Although recommended, a home visit is not required if only DME or supplies are needed and being requested by the physician on a Title XIX form. DME or supplies requested on a Home Health Services POC require an RN home evaluation. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client's physician for current reporting.

This evaluation should include assessment of the following:

- Medical necessity for home health services, supplies, or DME.
- Safety.
- Appropriateness of care in the home setting.
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition.

Following the RN's assessment/ evaluation of the client in the home setting for home health services needs, the agency RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the SOC.

24.4.2 Physician Supervision—Plan of Care

For the Home Health Services plan of care (POC) to be valid, the treating physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in condition.

Medicare Form 485 is not accepted as a POC. The Home Health Services POC is the only acceptable form for reimbursement from the Texas Medicaid Program.

24.4.2.1 Written Plan of Care

A Home Health Services POC is required for SN services, HHA, PT, and OT services. The POC is not required as an attachment with the claim, but a signed and dated POC must be retained in the client's medical record with the provider and requesting physician. The client's attending physician must recommend, sign, and date a POC. The POC does not need to be signed by the physician before contacting TMHP for authorization when orders for home care have been received from the physician. The POC shall be initiated by the RN in a clear and legible format. The POC must contain the following information:

- Activities permitted.
- All pertinent diagnoses.
- Available caregiver.
- Client Medicaid number.
- Date the client was last seen by the physician. The client must be seen by a physician within *30 days* of the initial SOC and at least once every six months thereafter unless a diagnosis has been established by the physician and the client is currently undergoing physician care and treatment. The physician visit may be waived when a diagnosis has already been established by the physician and the recipient is under the continuing care and medical supervision of the physician. Any waiver must be based on the physician's written statement that an additional evaluation visit is not medically necessary. The original must be maintained by the requesting physician and a copy must be maintained in the providing provider's files.
- Equipment/ supplies required.
- Instructions for timely discharge or referral.

- List all community or state agency services the client receives in the home (e.g., primary home care [PHC], PCS, community-based alternative [CBA], Medically Dependent Children's Program [MDCP]).
- Medications including the dose, route, and frequency.
- Mental status.
- Nutritional requirements.
- Physician license number.
- Prior and current functional limitations.
- Prognosis.
- Provider Medicaid number.
- Rehabilitation potential.
- Safety measures to protect against injury.
- SOC date for home health services.
- Treatments, including amount, duration, and frequency.
- Types of services including amount, duration, and frequency.
- Wound care orders and measurements.

Physician orders for PT and/or OT services must include the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis codes for an acute or exacerbated event, if the following conditions apply:

- PT/OT is being requested.
- Specific procedures and modalities are to be used.
- Amount, frequency, and duration of therapy needed.
- Physical and/or occupational therapy and goals.
- Name of therapist who participated in developing the POC is listed.

The physician and home health agency nursing, PT, and OT personnel must review the POC as often as the severity of the client's condition requires or at least once every 60 days. This signed and dated documentation must be maintained in the client's medical record with the ordering physician and requesting provider. This applies to all written and verbal orders, and plans of care.

Verbal physician orders may only be given to people authorized to receive them under state and federal law. They must be reduced to writing, signed, and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered service, and placed in the client's chart. The physician must sign the written copy of the verbal order within two weeks or per agency policy if less than two weeks. A copy of the written verbal order must be maintained in the client's chart before and after being signed by the physician.

The type and frequency of visits, supplies, or DME must appear on the POC before the physician signs the orders, and may not be added after the physician has signed the orders. If any change in the POC occurs during an authorization period (additional visits, supplies, or DME), the home health agency must call TMHP Home Health Services Authorization Department for authorization and maintain a completed revised request POC signed by the physician.

Coverage periods do not necessarily coincide with calendar weeks or months but instead cover a number of services to be scheduled between a start and end date that is assigned during the prior authorization. The agency *must* contact TMHP within three business days after the SOC date for prior authorization.

Refer to: "Home Health Services Plan of Care (POC)" on page B-47.

"Physical Therapy (PT) Services" on page 24-14.

24.5 Benefits

Home health services include SN services, HHA visits, PT visits, OT visits, DME, and expendable medical supplies that are provided to eligible Medicaid clients at their place of residence.

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary DME. DME is medically necessary when it is required to correct or ameliorate disabilities or physical or mental illnesses or conditions. Any numerical limit on the amount of a particular item of DME can be exceeded for Medicaid beneficiaries under 21 years of age if medically necessary. Likewise, time periods for replacement of DME will not apply to Medicaid beneficiaries under 21 years of age if the replacement is medically necessary. When prior authorization is required, the information submitted with the request must be sufficient to document the reasons why the requested DME item or quantity is medically necessary.

Medicaid beneficiaries under 21 years of age are entitled to all medically necessary PDN services and/or home health SN services. Nursing services are medically necessary when the requested services are nursing services as defined by the Texas *Nursing Practice Act* and its implementing regulations; the requested services correct or ameliorate the beneficiary's disability or physical or mental illness or condition; and there is no third party resource financially responsible for the services. Requests for nursing services must be submitted on the required Medicaid forms and include supporting documentation. The supporting documentation must: clearly and consistently describe the beneficiary's current diagnosis, functional status and condition; consistently describe the treatment throughout the documentation; and provide a sufficient explanation as to how the requested nursing services correct or ameliorate the beneficiary's disability or physical or mental illness or condition. Medically necessary nursing services will be authorized either as PDN services or as Home Health SN services, depending on whether the beneficiary's nursing needs can be met on a per visit basis.

Prior authorization must be obtained for all professional services, some supplies, and most DME from TMHP within *three business days of 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 been completed and signed by the client's attending physician.

For reimbursement, providers should note the following:

- The client's attending physician must request professional and/ or HHA services through a home health agency, and sign and date the POC.
- Claims are approved or denied according to the eligibility, prior authorization status, and medical appropriateness.
- Claims must represent a quantity of 1 month for supplies billed.
- Nursing, nurse aide, PT, and OT services must be provided through a Medicaid-enrolled home health agency. These services must be billed using the home health agency's provider identifier. File these services on a UB-04 CMS-1450 claim form.
- PT, OT, and/ or speech therapy (ST) are always billed as POS 2 and may be authorized to be provided in the following locations: home of the client, home of the caregiver/ guardian, client's day care facility, or the client's school. Services provided to a client on school premises are only permitted when delivered before or after school hours. The only THSteps-CCP therapy that can be delivered in the client's school during regular school hours are those delivered by school districts as School Health and Related Services (SHARS) in POS 9.
- 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 and younger and are not a benefit of Home Health Services. These services may be considered a benefit for clients who qualify for THSteps-CCP.*

Use the following type of service (TOS) codes when providing home health services:

TOS	Description
1	Medical services (including some injectable drugs)
9	Medical supplies
C	Home Health Procedure
J	Purchase (new)
L	Rental, monthly

24.5.1 Home Health Skilled Nursing Services

Home health SN services are a benefit of the Home Health Services when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically has an end-point. SN visits may be provided on consecutive days. SN visits are intended to provide SN care to promote independence and support the client living at home. Home Health Services must be provided by a licensed and certified home health agency enrolled in the Texas Medicaid Program.

Note: *Nursing visits for the primary purpose of assessing a client's care needs to develop a POC are considered administrative and not billable. These visit costs are reflected on the cost report.*

An *acute condition* is considered a condition or exacerbation that is anticipated to improve and reach resolution within 60 days. An intermittent basis is considered an SN visit provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day. A part-time basis is considered an SN visit provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

SN visits are considered medically necessary for clients who require the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments/ procedures.
- Individualized, intermittent, acute skilled care.
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function.
  - Imminent risk to health status due to medical fragility, or risk of death.

When documentation does not support medical necessity for home health SN visits, providers may be directed to possible alternative services based on the client's age and needs.

24.5.1.1 Skilled Nursing Visits

All SN services must be prior authorized.

SN visits are limited to SN procedures performed by an RN or LVN licensed to perform these services under the *Texas Nursing Practice Act* and include direct SN care, and parent or guardian, caregiver training, and education as well as SN observation, assessment, and evaluation by an RN, provided a physician specifically requests that a nurse visit the client for this purpose, and the physician's order reflects the medical necessity for the visit.

For all clients, SN visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver.
- Foster homes.
- Independent living arrangements.

Skilled Nursing Care

Skilled nursing care consists of those services that must, under state law, be performed by a RN or LVN, and meet the criteria for SN services specified in the Title 42 *Code of Federal Regulations* (CFR) §§ 409.32, 409.33, and 409.44).

In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the client, and the accepted standards of medical and nursing practice.

The fact that the SN service can be, or is, taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.

If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be an SN service.

If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as an SN service.

Some services are classified as SN services on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client's illness or injury, would be covered on that basis. However, in some cases, the client's condition may cause a service that would ordinarily be considered unskilled to be considered an SN service. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.

A service which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client's family, or other caregivers. Where the client needs the SN care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.

The SN services must be reasonable and necessary to the diagnosis and treatment of the client's illness or injury within the context of the client's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client's particular medical needs, and within accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled services are needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration of the physician's determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

The SN care must be provided on a part-time or intermittent basis.

Professional Nursing

Professional nursing provided by an RN, as defined in the *Texas Nurse Practice Act*, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

Professional nursing also involves assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

Vocational Nursing

Vocational nursing, as defined in the *Texas Nurse Practice Act*, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.

Vocational Nursing also involves assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs and engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

Use procedure code C-G0154 for SN services.

24.5.2 Home Health Aide Services

HHA visits are a benefit of Home Health Services when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. HHA visits are intended to provide personal care services under the supervision of a RN, PT, or OT employed by the home health agency to promote independence and support the client living at home.

HHA visits are considered medically necessary for clients who require general supervision of nursing care provided by an HHA over whom the RN is administratively or professionally responsible in addition to the following:

- Skillful observations and judgment to improve health status, skilled assessment, or skilled treatments or procedures.
- Individualized, intermittent, acute skilled care.
- Skilled interventions to improve health status, and if skilled intervention is delayed, it is expected to result in the deterioration of a chronic condition or one of the following:
  - Loss of function.
  - Imminent risk to health status due to medical fragility, or risk of death.

When documentation does not support medical necessity for HHA visits, providers may be directed to possible alternative services based on the client's age and needs.

24.5.2.1 Home Health Aide Visits

HHA visits are intended to provide hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered.

Any HHA services offered by a home health agency must be provided by a qualified HHA under the supervision of a qualified licensed individual (RN, PT, OT) employed by the home health agency.

For all clients, HHA visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver.
- Foster homes.
- Independent living arrangements.

The duties of an HHA during a visit include, but are not limited to:

- Ambulation.
- Assistance with medication that is ordinarily self-administered.
- Assisting with nutrition and fluid intake.
- Completing appropriate documentation.
- Exercise.
- Household services essential to the client's health care at home.
- Obtaining and recording the client's vital signs (temperature, pulse, respirations, and blood pressure).
- Observation, reporting and documentation of the client's status, and the care or service furnished.
- Personal care (hygiene and grooming) including but not limited to:
  - Sponge, tub or shower bath.
  - Shampoo, sink, tub or bed bath.
  - Nail and skin care.
  - Oral hygiene.
- Positioning.
- Range of motion.
- Reporting changes in the client's condition and needs.
- Safe transfer.
- Toileting and elimination care.

Use procedure code C-G0156 when billing for HHA services.

24.5.2.2 Supervision of Home Health Aides

Supervision, as defined by the *Texas Nurse Practice act*, is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity.

A RN or therapist (PT/OT) must provide the HHA written instructions for all the tasks delegated to the HHA. A therapist may prepare the written instructions if the client is receiving only HHA visits, which do not include delegated SN tasks, in addition to the therapy services.

The requirements for HHA supervision are as follows:

- When only HHA visits are provided, an RN must make a supervisory visit to the client's residence at least once every 60 days. The supervisory visit must occur when the HHA is providing care to the client.
- When SN, PT, and/or OT visits are provided in addition to a HHA visit, an RN must make a supervisory visit to the client's residence at least every two weeks. The supervisory visit must occur when the HHA is providing care to the client.
- When only PT and/or OT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

24.5.3 Home Health Skilled Nursing and Home Health Aides Services Provider Responsibilities

Providers must be a licensed home health agency enrolled in the Texas Medicaid Program and must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid Program policies and procedures. All providers must maintain written policies and procedures for obtaining consent for medical treatment for clients in the absence of the primary caregiver that meet the standards of the *Texas Family Code*, Chapter 32, and obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.

Providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the place of service. The essential elements of safe and effective home health SN and/or HHA services include a trained parent, guardian, or caregiver, a primary physician, competent providers, and an environment that supports the client's health and safety needs.

The place of service must be able to support the health and safety needs of the client and must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and back-up utility, communication, and fire safety systems must be available.

Note: *A parent or guardian, primary caregiver, or alternate caregiver may not provide SN and/or HHA services even if he or she is an enrolled provider or employed by an enrolled provider.*

24.5.4 Home Health Skilled Nursing and Home Health Aide Services Prior Authorization Requirements

SN services and HHA visits require prior authorization. Requests must be submitted by fax or in writing by mail. Providers must obtain authorization within three business days of the SOC date for an initial authorization. For recertifications, providers must obtain authorization within seven business days of the new SOC date. During the authorization process, providers are required to deliver the requested services from the SOC date which is the date agreed to by the physician, the RN, the home health agency, and the client, parent, guardian, or caregiver. The SOC must be documented on the POC. A provider requesting prior authorization for SN and/or HHA Services must submit the following documentation:

- A completed client assessment.
- A completed Texas Medicaid Home Health Services POC that must:
  - Be signed and dated by the assessing RN.
  - Signed and dated by the physician or submitted with the signed and dated physician's orders.

Prior authorization of SN or HHA visits requires that a client's primary care physician complete the following steps:

- Provide specific, written, dated orders for SN or home health agency visits or recertification that identifies that the prescribed visits are medically necessary as defined in the Statement of Benefits.
- Maintain documentation in the client's medical record that supports the medical necessity of the prescribed visits.
- Maintain documentation in the client's medical record that demonstrates that the client's medical condition is sufficiently stable to permit safe delivery of the prescribed visits as described in the client's Home Health Services POC.
- Establish a medical plan of care that is maintained in the client's medical record.
- Provide continuing care and medical supervision.
- Review and approve the client's Home Health Services POC once every 60 days or more frequently as the physician determines necessary, including but not limited to a change in the client's condition.

All signatures must be current, unaltered, original, and handwritten; computerized or stamped signatures will not be accepted. All documentation, including all written and verbal orders, and all physician-signed POCs, must be maintained by the ordering physician, and the home health agency must keep the original, signed copy of the POC in the client's medical record.

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN and/or HHA visits that will safely meet the client's needs. The amount and duration of SN and/or HHA visits requested will be evaluated by the claims administrator. The home health agency must ensure the requested services are supported by the client assessment, POC, and the physician's orders.

The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, home health agency, RN, and client, parent, guardian, or caregiver. SN and HHA visits will be prior authorized for no more than 60 days at a time. As a client's problems are resolved and goals are met, a client's condition is expected to become more stable, and the client's needs for SN and HHA services may decrease.

SN visits to obtain routine laboratory specimens may be considered when the only alternative to obtain the specimen is to transport the client by ambulance. SN visits to address hyperbilirubinemia will not be considered for prior authorization if the client has an open authorization for home phototherapy. Home phototherapy is reimbursed as a daily global fee and includes coverage of SN visits for client or parent, caregiver teaching and monitoring, and customary and routine laboratory work.

SN visits to address total parenteral nutrition (TPN)/ hyperalimentation will not be considered for prior authorization if the client has an open authorization for TPN/ hyperalimentation. TPN/ hyperalimentation is reimbursed as a daily global fee and includes coverage of SN visits for

client, parent, or caregiver teaching and monitoring, customary and routine laboratory work, and enteral supplies and equipment.

Up to a maximum combined total of three SN and HHA visits may be prior authorized per day. One visit may last up to a maximum of 2.5 hours. SN and/or HHA visits may be provided on consecutive days.

When documentation does not support medical necessity for home health SN and/or HHA visits, providers may be directed to possible alternative services based on the client's age and needs.

A prior authorization for SN and/or HHA visits is no longer valid when:

- The client is no longer eligible for Medicaid.
- The client no longer meets the medical necessity criteria for SN and/or HHA services.
- The place of service cannot provide for the health and safety of the client.
- The client, parent, guardian, or caregiver refuses to comply with the attending physician's plan of treatment and compliance is necessary to ensure the health and safety of the client.
- The client changes providers and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.

A nurse/HHA may be authorized to provide services to more than one client over the span of the day as long as each client's care is based on an individualized POC and each client's needs and POC do not overlap with another client's needs and POC. Settings in which a nurse/HHA provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving home health services, foster homes, and independent living arrangements.

24.5.4.1 Canceling an Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or 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, the current 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.

24.5.4.2 Home Health Skilled Nursing Services and Home Health AIDE Services that will not be Prior Authorized

SN visits requested primarily to provide the following will not be prior authorized:

- Respite care.
- Child care.
- Activities of daily living for the client.
- Housekeeping services.
- Routine post-operative disease, treatment, or medication teaching after a physician visit.
- Routine disease, treatment, or medication teaching after a physician visit.
- Individualized, comprehensive case management beyond the service coordination required by the *Texas Nurse Practice Act*.

HHA visits requested primarily to provide the following will not be prior authorized:

- Housekeeping services.
- Services provided to a client residing in a hospital, SN facility or intermediate care facility.

Certain facilities are required by licensure to meet all the medical needs of the client. SNV and/or HHA visits will not be authorized for clients receiving care in any of the following facilities:

- Hospitals.
- SN facilities.
- Intermediate care facilities for the mentally retarded (ICF-MR).
- Special care facilities, including but not limited to, subacute units, and facilities for the treatment of acquired immunodeficiency syndrome (AIDS).

24.5.5 Home Health Skilled Nursing and Home Health Aide Services Assessments and Reassessments

When a provider has received a referral and has physician orders for SN and/or HHA services, the provider must have a RN perform an initial client assessment in the client's home. A client can be referred to a home health agency for SN and/or HHA services by the client, the client's physician, or the client's family.

The client assessment or reassessment should include, but is not limited to, the following:

- Whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client.
- Comprehension level of client, parent, guardian, or caregiver.
- Receptivity to training and ability level of the client, parent, guardian, or caregiver.

- A nursing assessment of medical necessity for the requested visits which includes:
  - Complexity and intensity of the client's care.
  - Stability and predictability of the client's condition.
  - Frequency of the client's need for SN care.
  - Identified medical needs and goals.
  - Description of wounds, if present.
  - Cardiac status.

The initial assessment and any reassessments performed by a RN are required when changes in the client's condition occur during the course of the authorization period. If there is no change in the client's condition, the reassessment must document medical necessity, as defined in the Statement of Benefits, to support continued and ongoing SN and/or HHA visits beyond the initial 60-day authorization period.

24.5.6 Supplies Submitted with a Plan of Care

The cost of incidental supplies used during an SN visit or a HHA visit may be added to the charge of the visit ($10 maximum for supplies and included in C-G0154 visit code). Medical supplies left at the home for the client or a subsequent home health nurse to use must be billed with the provider identifier enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services Prior Authorization Department.

A home health agency provider may request prior authorization for supplies/DME by utilizing the Home Health Services POC or the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form.

The home health agency may utilize the Home Health Services POC to submit a prior authorization of supplies/DME that will be used in conjunction with the professional services provided by the agency, such as SN, PT, or OT. The home health agency's DMEH provider identifier must be submitted on the POC and all of the supplies that are requested must be listed in the supplies section of the POC. The POC does not require a physician's signature prior to submission for prior authorization of professional services/DME and supplies.

If the home health agency utilizes the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form, the agency must complete Section A. The physician must complete Section B, and sign prior to submission to TMHP for prior authorization of the requested supplies/DME.

The following information is required to consider these supplies for authorization:

- Item description.
- Procedure code.
- Quantity of each supply requested.
- MSRP for items that do not have a maximum fee assigned.

24.5.7 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not a benefit if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual's illness or is not Food and Drug Administration (FDA)-approved.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, and/or neighbor have been taught or can be taught to administer SQ/SC, IM, and IV injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

24.5.8 Physical Therapy (PT) Services

As stated in the TAC, in order to be payable as a Home Health Services benefit, PT services must be:

- Requested for a payable ICD-9-CM diagnosis code.
- Provided by a physical therapist or physical therapist assistant. A physical therapist assistant must be supervised by a licensed physical therapist who is currently licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners.
- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.
- Expected to improve the client's condition in a reasonable and generally predictable period of time, based on the physician's assessment of the client's restorative potential after any needed consultation with the therapist.
- The evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition.
- Specific goal-directed activities to achieve a functional level of mobility and communication and prevent further dysfunction within a reasonable length of time based on the therapist's evaluation and physician's assessment and POC.
- PT POC should encourage the client and other caregivers to learn self-therapy skills to the greatest extent possible while still providing all medically necessary services.
- Provided only until the client has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not a benefit. Services related to activities for the general good and

welfare of clients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.

- Billed by the home health agency and reimbursed to the home health agency.

Independently-enrolled therapists are not reimbursed under Home Health Services.

PT authorization must be requested by the home health agency's RN and recommended to be done after the RN home assessment. Requests are not accepted, nor authorization granted, directly to the PT or assistant PT.

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

Refer to: Section 24.3.1, "Eligibility."

24.5.8.1 Physical Therapy Prior Authorization Procedures

To obtain prior authorization for initial and recertification of PT services provided through a home health agency, providers should contact the TMHP Home Health Services Prior Authorization Department at 1-800-925-8957. Home health agencies must provide an initial or subsequent POC to include PT goals, accurate diagnostic information (including ICD-9-CM diagnosis codes) and PT procedure codes and PT evaluation or re-evaluation results at the time a request is made using the POC.

Use the procedure codes listed in "Physical Therapy/ Occupational Therapy Procedure Codes" on page 24-15 of this manual to submit claims for PT services provided through a home health agency. Indicate modifier AT (indicating the service procedure is an acute treatment) on each PT procedure code. PT services should be billed on a UB-04 CMS-1450 claim form.

Refer to: "THSteps-Comprehensive Care Program (CCP)" on page 43-33 for physical therapy services that are not billed as home health services.

"Modifiers" on page 5-18.

24.5.8.2 Limitations

PT services must be billed with the AT modifier and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. PT must be billed with CPT procedure codes.

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Use procedure code C-97001 for Physical Therapy evaluation codes. PT evaluations are payable once every 180 days for any provider. Use procedure code C-97002 for Physical Therapy re-evaluations. PT re-evaluations are payable one time per month for any provider. Procedure codes C-97001 and C-97002 are not payable on the same day as the following procedure codes:

Procedure Codes		
C-97012	C-97014	C-97016
C-97018	C-97022	C-97024
C-97026	C-97028	C-97032
C-97033	C-97035	C-97039
C-97110	C-97112	C-97116
C-97124	C-97139	C-97140
C-97150	C-97530	

To request wheelchair evaluations, use procedure code 1-97001.

24.5.9 Physical Therapy/ Occupational Therapy Procedure Codes

Procedure Codes		
C-97012	C-97014	C-97016
C-97018	C-97022	C-97024
C-97026	C-97028	C-97032
C-97033	C-97035	C-97039
C-97110	C-97112	C-97116
C-97124	C-97139	C-97140
C-97150	C-97530	C-97535
C-97537	C-97542	C-97799

The procedure codes listed above for PT and OT are only payable to Home Health Agencies. Independently enrolled occupational therapists are not paid under Home Health Services.

Therapy services that can be designated either as PT or OT must be requested and billed with the correct procedural modifier.

Modifier	Visit Service Category
GP	PT
GO	OT

PT and OT must be billed with the AT modifier and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. PT and OT services are to be billed with CPT procedure codes.

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start of therapy. If the condition persists for more than

180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is the point at which maximal improvement has been documented and further improvement ceases.

24.5.10 Occupational Therapy (OT) Services

As stated in the TAC, to be payable as a Home Health Services benefit, OT services must be:

- Requested for a payable ICD-9-CM diagnosis code.
- Provided by an occupational therapist or an occupational therapy assistant who is currently registered and licensed by the Executive Council of Physical Therapy and Occupational Therapy Examiners. An occupational therapy assistant must be supervised by a licensed occupational therapist.
- For the treatment of an acute musculoskeletal or neuromuscular condition or an acute exacerbation of a chronic musculoskeletal or neuromuscular condition.

OT authorization must be requested by the home health agency's RN and recommended to be done after the RN assessment. Requests are not accepted, nor authorization granted, directly to the occupational therapist or OT assistant.

- For the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition.
- For specific goal-directed activities to achieve a functional level of mobility and communication and prevent further dysfunction within a reasonable length of time based on the therapist's evaluation and physician's assessment and POC.
- Provided only until the client has reached the maximum level of improvement. Repetitive services designed to maintain function when the maximum level of improvement has been reached are not reimbursed. Services related to activities for the general good and welfare of clients, such as general exercises to promote overall fitness and flexibility, and activities to provide diversion or general motivation are not reimbursed.

Refer to: "Occupational Therapists (THSteps-CCP Only)" on page 43-60.

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

Refer to: Section 24.3.1, "Eligibility."

24.5.10.1 Occupational Therapy Prior Authorization Procedures

To obtain prior authorization for the initial and recertification of OT services provided through a home health agency, providers should contact the TMHP Home Health Services Prior Authorization Department at 1-800-925-8957. Home health agencies must provide accurate diagnostic information (including ICD-9-CM diagnosis codes), OT procedure codes, and an initial or subsequent plan of care to include OT goals.

Use the codes listed under "Physical Therapy/ Occupational Therapy Procedure Codes" to submit claims for OT services that are provided through a home health agency. Bill OT services on a UB-04 CMS-1450 claim form. Use procedure code 1-97003 when requesting prior authorization and billing for wheelchair evaluations.

24.5.10.2 Limitations

OT services must be billed with the AT modifier. Services must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. OT is billed using CPT procedure codes.

The AT modifier is described as "representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start of therapy." If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing.

Plateauing is the point at which maximal improvement has been documented and further improvement ceases. Use procedure codes C-97003 and C-97004 when billing for OT evaluation and re-evaluations.

24.5.11 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 and 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 quantities for the services requested. A copy of the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form must be maintained by the DME provider and the original must be kept by the prescribing physician in the client's medical file.

- The provider *must* contact TMHP within three business days of providing the supplies to the client and obtain 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
  - The delivery slip or invoice must contain the client's full name and address to which the supplies were delivered, the item description and the numerical quantities that were delivered to the client.
  - 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 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.

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. 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.

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.

- 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.

Refer to: The list of DME/ medical supplies that may be provided without prior authorization are located in "Diabetic Supplies/ Equipment" on page 24-18; "Nebulizers" on page 24-58; "Vaporizers" on page 24-58; "Incontinence Supplies" on page 24-21; and "Procedure Codes That Do Not Require Prior Authorization" on page 24-67. The items must be used for therapeutic purposes and directly relate to the client's needs and POC.

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.

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

- 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 authorization can be made up to 60 days before the start of the new 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.*

- If a client or caregiver has been instructed and supervised on proper wound care technique and no longer requires SN services, the home health agency (enrolled as a DMEH provider) can continue to provide supplies that enable the client or caregiver to administer care. Supplies may be provided as long as the client meets home health services criteria. The following supplies

are those considered essential to the physician-prescribed treatment of an ill or injured client in their own home. Items not listed may, in selected instances, be required for a particular client. Consideration is given on an individual case basis to items not on this list that are medically documented by the physician's POC. *An RN must evaluate the client in the home setting before the initiation of the POC or have a Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form completed and signed by a treating physician serving as a POC for DME and/or 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 THSteps-CCP.*

Refer to: "Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)" on page B-42 and "Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form" on page B-44 for copies of forms.

"Durable Medical Equipment Supplier (THSteps-CCP Only)" on page 43-45 for specific information about certain DME and medical supplies.

"Medicare/Medicaid Authorization" on page 24-71 for a list of supplies that do not require prior authorization.

"Eligibility" on page 24-5.

24.5.11.1 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.

24.5.11.2 Canceling an Authorization

The client has the right to choose their DME/medical supply provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or 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, the current 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.

24.5.12 Diabetic Supplies/Equipment

Diabetic supplies and equipment are a benefit through Home Health Services. Diabetic supplies and related testing equipment do not require prior authorization unless otherwise specified. The following requirements must be met to qualify for reimbursement:

- The client must be eligible for home health benefits.
- The equipment must be medically necessary.
- The criteria appropriate for the requested equipment must be met.
- Federal financial participation must be available.
- The requested equipment or supplies must be safe for use in the home.

The DME Certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This signed and dated form must be maintained by the DME provider in the client's medical record.

Glucose monitors and external insulin pumps that have been purchased are anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate or applicable, and the measures to be taken to prevent reoccurrence must be submitted. Additional services may be reimbursed with prior authorization based on documentation of medical necessity.

In situations where the equipment has been abused or neglected by the client, the client's family or the caregiver, a referral to the Department of State Health Services (DSHS) THSteps Case Management Department will be made by the Home Health Services Prior Authorization Department for clients under 21 years of age. Providers will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and the equipment.

A Texas Medicaid-eligible client may obtain diabetic supplies and related testing equipment through Home Health Services. The following requirements must be met to qualify for reimbursement under Home Health Services:

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that prescribes the DME and/or medical supplies must be signed and dated by a prescribing physician who is familiar with the client before supplying any medical equipment or supplies. All signatures must be current, unaltered, original, and hand written. Computerized or stamped signatures and dates will not be accepted. The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must be maintained by the provider and the prescribing physician

in the client's medical record. The physician must maintain the original signed and dated copy of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form is valid for a period up to six months from the physician's signature date.

The physician must indicate on the Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form how many times a day the client is required to test blood glucose levels.

24.5.12.1 Blood Testing Supplies

Blood testing supplies for diagnoses other than those listed in the diagnosis table below may be considered for prior authorization with documentation of medical necessity. 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 of blood testing supplies beyond those listed in the procedure code table below for diabetic supplies and limitations, when requested for a diagnosis listed in the diagnosis table below, may be considered for prior authorization with documentation of medical necessity related to the number of tests the physician ordered per day. Blood testing supplies will be reimbursed for the quantities listed in the procedure code table below for diabetic supplies and limitations, or the quantity that was prior authorized.

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.

Note: *THSteps-eligible clients who qualify for medically necessary services beyond the limits of this home health benefit will receive those services through THSteps-CCP. Glucose tabs/gel may be billed with procedure code 9-A9150.*

Blood glucose test/ reagent strips (9-A4253) and home glucose disposable monitors with test strips (9-A9275) are limited to a combined total of four per month without prior authorization.

Diabetic Supplies and Limitations

Procedure Code	Maximum Limit
9-A4233	1 per 6 months
9-A4234	1 per 6 months
9-A4235	1 per 6 months
9-A4236	1 per 6 months
9-A4245	As needed
9-A4250	2 boxes/ month
9-A4253	4 boxes/ month* *Combined total with A9275
9-A4256	2 per year
9-A4258	2 per year
9-A4259	2 boxes/ month
9-A4601	1 per 6 months
1-A9150	1 per 6 months* *Use this procedure code for Glucose tabs/ gel
9-A9275	4 per month* *Combined total with A4253

Diagnosis Codes

Diagnosis Code				
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
64800	64801	64802	64803	64804
64880	64881	64882	64883	64884
7751				

Diagnoses not listed above may be considered by HHSC with supporting documentation of medical necessity.

Diabetic supplies and related testing equipment do not require prior authorization unless otherwise specified by HHSC.

24.5.12.2 Blood Glucose Monitors

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

Prior authorization is not required for the purchase of a standard blood glucose monitor (J-E0607), but is limited to the diagnoses listed in the diagnosis table above. Diagnoses not listed may be considered for prior authorization with supporting documentation of medical necessity.

Invasive continuous glucose monitors (CGMs) are used for diagnostic purposes to assist the clinician in establishing or modifying a client's treatment plan. Invasive CGMs are not benefits of Home Health Services. Noninvasive CGMs are considered investigational and are not benefits of the Texas Medicaid Program.

Prior authorization for blood glucose monitors with special features (procedure codes J-E2100 and J-E2101), such as auditory responses for visually impaired clients may be considered with documentation that supports the medical necessity of the special feature that was requested. This

can be requested either by calling TMHP Home Health Services Prior Authorization Department, or by faxing the Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form to TMHP Home Health Services Prior Authorization Department.

To avoid unnecessary denials, physicians must provide correct and complete information, including documentation of the medical necessity of the equipment and/ or supplies that are requested. Physicians must maintain documentation of medical necessity in the client's medical record. Requesting providers may be asked for additional information to clarify or complete a request for diabetic equipment or supplies.

Purchase of a blood glucose monitor with integrated voice synthesizer (J-E2100) may be prior authorized with documentation that includes a diagnosis of diabetes and significant visual impairment, including a statement from the physician that the client is unable to use a regular monitor and that the visual impairment is not correctable.

Purchase of a blood glucose monitor with integrated lancing/ blood sample (J-E2101) may be prior authorized with documentation that includes a diagnosis of diabetes and significant manual dexterity impairment related to, but not limited to, neuropathy, seizure activity, cerebral palsy, or Parkinson's. The documentation must include a statement from the physician that the client is unable to use a regular monitor and has a significant manual dexterity impairment that is not correctable.

The documentation and a completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form must be submitted to the Home Health Services Prior Authorization Department.

24.5.12.3 Insulin and Insulin Syringes

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

24.5.12.4 Insulin Pump

The following procedure codes for the external insulin pumps and associated supplies are a benefit of the Texas Medicaid Program and may be considered through Home Health Services. Note that a replacement leg bag may be requested with procedure code 9-A9900. *The initial leg bag is part of the purchase of the pump.*

Insulin Pump Procedure Codes and Limitations

Procedure Code	Maximum Limitation
9-A4230	10 per month
9-A4231	15 per month
9-A4232	10 per month
9-A4601	1 per 6 months
9-A6257	15 per month
9-A6258	15 per month
9-A6259	15 per month
9-A9900	Leg bag replacement only
J-E0784	1 per 5 years
L-E0784	3 months trial

Prior authorization is required for external insulin pumps (J/ L-E0784) with carrying cases and their related supplies. The external insulin pump supplies may be reimbursed separately in addition to the external insulin pump rental.

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, brittle diabetes, 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.
- Completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form.

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

An internal insulin pump will not be prior authorized, because reimbursement for the pump is included in the reimbursement for the surgery to place the insulin pump.

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

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of medical necessity for the equipment and/ or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the diabetic equipment or supplies.

24.5.13 Incontinence Supplies and Equipment

Incontinence supplies and DME are defined as disposable supplies such as diapers, briefs, pull-ons, liners, wipes, underpads, skin sealants, protectants, moisturizers, ointments, and DME that are used by a client who has a medical condition that results in a chronic impairment of urination and/or stooling, or that renders them unable to ambulate safely to the bathroom (with or without mobility aids). For the purpose of this policy, a chronic impairment of urination and/or stooling is defined as a condition that is not expected to be medically or surgically corrected and that is of a long and indefinite duration (at least three months).

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. 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.

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.

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.

The Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is valid for up to, but no more than, six months from the date of the physician's signature on the form.

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

Refer to: Section 24.3.1, "Eligibility."

24.5.13.1 Incontinence Supplies

Skin sealants, protectants, moisturizers, and ointments for clients 4 years of age and 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. Skin sealants, protectants, moisturizers and ointments are limited to a maximum of two per month for clients four years of age and older. Prior authorization for clients younger than 4 years of age must be obtained through THSteps-CCP.

Note: 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.*

For clients four years of age and 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 month. Amounts beyond 300 per month may be considered for reimbursement when prior authorized. A combination of diapers, briefs, and liners may be considered for reimbursement. A total accumulation of one or more of the following products is limited to a maximum of 300 per month: diapers, briefs, pull-ons, and liners. Amounts beyond 300 per month require prior authorization. Reusable diapers/briefs are not a benefit of Home Health Services.

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.*

Diaper wipes (9-A4335), other than urinary skin cleansing products, may be considered for reimbursement without prior authorization for clients who are 4 years of age and older and are also receiving diapers/briefs/pull-ons. Diaper wipes, other than urinary skin cleansing products, are limited to a maximum of two boxes per month. Exceptions will not be considered through Home Health Services. Additional quantities may be considered through THSteps-CCP for clients who are younger than 21 years of age with documentation of medical necessity and prior authorization.

Note: *Providers are to bill procedure code 9-A4335 instead of procedure code 9-A5120 when providing diaper wipes. Inappropriate billing of 9-A5120 will cause the procedure to deny.*

Underpads may be considered for reimbursement without prior authorization for clients who also receive diapers/ briefs, urine collection devices, or bowel management supplies. Underpads are limited to a maximum of 150 per 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, unless it has been prior authorized.*

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

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.

Note: *Nonsterile gloves may be considered for reimbursement with prior authorization when a family member or friend is performing the catheterization. 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.*

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. Indwelling catheters and related supplies are limited to a maximum of two per month. More than two indwelling catheters and related insertion supplies per month requires prior authorization. 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 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. More than 120 intermittent catheters and related insertion supplies requires prior authorization. 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.

Use procedure codes 9-A4351, and/ or 9-A4352 when billing for intermittent catheters. Use procedure code 9-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 for clients 4 years of age and 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. 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. Prior authorization is required for medically necessary services beyond the limits listed in the Incontinence Procedures and Limitations table. 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.

External urinary collection devices for clients younger than 4 years of age require prior authorization through THSteps-CCP. 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.

24.5.13.2 Incontinence Equipment

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

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). Urinals and bed pans

are considered a purchase as a purchase only. Urinals and bed pans that exceed two per year may be considered with prior authorization.

Commode chairs and foot rests will be considered for prior authorization and reimbursement based on the level of need. 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 foot rest if the client also has a stationary bath chair without a commode cutout.

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).

Use procedure codes J-E0163 or J-E0165 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 THSteps-CCP for clients under 21 years of age.

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 THSteps-CCP for clients under 21 years of age.

Use procedure codes J-E0163 or J-E0165 and modifier TG (custom) when billing for custom stationary or mobile commode chairs.

Use procedure codes J-E0163 or J-E0165 and modifier TF (non-custom mobile) when billing for non-custom mobile commode chairs.

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.

Use procedure code J-E0168 and modifiers TF (mobile) or TG (custom) for an extra-wide/ heavy-duty commode chair.

Foot Rest

A *foot rest* is used to support feet during use of commode chair and 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.

Use procedure code J-E1399 when billing for a foot rest.

Replacement Commode Pail/ 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.

Use procedure code J-E0167 when billing for a commode pail or pan.

24.5.13.3 Incontinence Procedure Codes With Limitations

Note: *Any service or combination of services not identified with a # next to the procedure code, except diaper wipes, requires prior authorization if the maximum limitation is exceeded. Items identified with a # always require prior authorization. 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
9-A4310	2 per month
9-A4311	2 per month
9-A4312	2 per month
9-A4313	2 per month

Procedure Code	Maximum Limitation
9-A4314	2 per month
9-A4315	2 per month
9-A4316	2 per month
9-A4320	2 per month
9-A4322	4 per month
9-A4326	31 per month
9-A4327	4 per month
9-A4328	4 per month
9-A4330	As needed
9-A4335	2 per month
9-A4338	2 per month
9-A4340	2 per month
9-A4344	2 per month
9-A4346	2 per month
9-A4349	31 per month
9-A4351	120 per month
9-A4351-SC	120 per month
9-A4352	120 per month
9-A4352-SC	120 per month
9-A4353	120 per month
9-A4353-SC	120 per month
9-A4354	2 per month
9-A4355	2 per month
9-A4356	2 per month
9-A4357	2 per month
9-A4358	2 per month
9-A4361	As needed
9-A4362	As needed
9-A4363	As needed
9-A4364	As needed
9-A4365	1 box of 50 per month
9-A4367	As needed
9-A4368	As needed
9-A4369	As needed
9-A4371	As needed
9-A4372	As needed
9-A4373	As needed
9-A4375	As needed
9-A4376	As needed
9-A4377	As needed
9-A4378	As needed
9-A4379	As needed
9-A4380	As needed
9-A4381	As needed

Procedure Code	Maximum Limitation
9-A4382	As needed
9-A4383	As needed
9-A4384	As needed
9-A4385	As needed
9-A4387	As needed
9-A4388	As needed
9-A4389	As needed
9-A4390	As needed
9-A4391	As needed
9-A4392	As needed
9-A4393	As needed
9-A4394	As needed
9-A4395	As needed
9-A4396	As needed
9-A4397	As needed
9-A4398	As needed
9-A4399	As needed
9-A4400	As needed
9-A4402	4 per month
9-A4404	As needed
9-A4405	As needed
9-A4406	As needed
9-A4407	As needed
9-A4408	As needed
9-A4409	As needed
9-A4410	As needed
9-A4411	As needed
9-A4412	As needed
9-A4413	As needed
9-A4414	As needed
9-A4415	As needed
9-A4418	As needed
9-A4420	As needed
9-A4421	As needed
9-A4422	As needed
9-A4428	As needed
9-A4455	4 per month
9-A4554	150 per month
9-A4927#	1 per month
9-A5051	As needed
9-A5052	As needed
9-A5053	As needed
9-A5054	As needed
9-A5055	As needed

Procedure Code	Maximum Limitation
9-A5061	As needed
9-A5062	As needed
9-A5063	As needed
9-A5071	As needed
9-A5072	As needed
9-A5073	As needed
9-A5081	As needed
9-A5082	As needed
9-A5093	As needed
9-A5102	2 per month
9-A5105	4 per year
9-A5112	2 per month
9-A5113	2 per month
9-A5114	2 per month
9-A5120	30 per month
9-A5121	As needed
9-A5122	As needed
9-A5126	As needed
9-A5131	1 per month
9-A5200	2 per month
9-A6250#	2 per month
9-T4521	*300 per Month
9-T4522	*300 per Month
9-T4523	*300 per Month
9-T4524	*300 per Month
9-T4525	*300 per Month
9-T4526	*300 per Month
9-T4527	*300 per Month
9-T4528	*300 per Month
9-T4529	*300 per Month
9-T4530	*300 per Month
9-T4531	*300 per Month
9-T4532	*300 per Month
9-T4533	*300 per Month
9-T4534	*300 per Month
9-T4535	*300 per Month
9-T4543	*300 per month
J-E0163#	1 per 5 years
J-E0163-TF#	1 per 5 years
J-E0163-TG#	1 per 5 years
J-E0165#	1 per 5 years
J-E0165-TF	1 per 5 years
J-E0165-TG#	1 per 5 years
J-E0167#	1 per year
J-E0168#	1 per 5 years
J-E0168-TF#	1 per 5 years
J-E0168-TG#	1 per 5 years
J-E0175#	1 per 5 years
J-E0275	2 per year
J-E0276	2 per year
J-E0325	2 per year
J-E0326	2 per year

Refer to: The Diapers/Briefs/Liners section of "Incontinence Supplies and Equipment" on page 24-21 for an explanation of the item limitations identified with an asterisk (*).

24.5.13.4 Modifiers

Modifier		
TF	TG	SC

24.5.14 Wound Care Supplies and/or Systems

Wound care supplies and systems are designed to assist in healing of wounds in conjunction with an individualized wound care therapy regimen prescribed by a physician. A wound care system includes a medical device and its component supplies designed to assist in healing of wounds unresponsive to conventional wound care therapy. Wound care supplies and wound care systems may be considered for reimbursement through Home Health Services.

Refer to: "Wound Care Supplies and/or Systems" on page 24-25 for more information.

Prior authorization is required for all the medical supplies and wound care systems addressed in this policy 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 THSteps-CCP.*

24.5.14.1 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 authori-*

zation. Dressing supplies for tracheostomies and/or gastrostomies may be considered for prior authorization with documentation of medical necessity.

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.

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

24.5.14.2 Wound Care System

A wound care system includes a medical device and its component supplies designed to assist in healing of wounds unresponsive to conventional wound care therapy. 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.* A heating element provides and maintains a warm, moist wound environment and protects the wound during the healing process by sealing it with an adhesive drape and applying intermittent heat to the surrounding tissue.
- *Sealed suction wound care system.* A sealed suction wound care system provides and maintains a moist wound environment and protects the wound during the healing process by sealing it with an adhesive drape and applying continuous or intermittent suction.

Note: *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.*

24.5.14.3 Thermal Wound Care System

A thermal wound care system consists of an occlusive pocketed wound cover with foam buffer to cover the wound, a warming card that is placed in the wound cover pocket and an electric temperature control unit (TCU). A thermal wound care system delivers safe, controlled warmth to the wound site and peri-wound tissue—without touching the wound. This warmth temporarily increases blood flow and SQ/SC oxygen to the wound and surrounding area to facilitate healing.

Dressing changes associated with a thermal wound care system are performed every one to three days, depending on the amount of exudate produced by the wound. The warming card is used on a single client, but is not required to be changed during treatment except to accommodate a decreasing wound size. The TCU is rented on a monthly basis. The client, family, or caregiver can be taught to perform a thermal wound care system dressing change.

Use procedure codes 9-A6000, L-E0231, and L-E0232 for a thermal wound care system and associated supplies.

24.5.14.4 Sealed Suction Wound Care System

A sealed suction wound care system consists of a cell foam dressing that is placed in the wound bed, a suction catheter tip, an adhesive drape to cover the wound, suction tubing, and a computerized vacuum pump. A sealed suction wound care system uses continuous or intermittent subatmospheric pressure to evacuate the excess interstitial fluid and remove growth factor inhibitors. The removal of inhibitors allows the growth factor to stimulate cell proliferation and migration. Removal of excess fluid also helps decrease peri-wound induration.

Dressing changes associated with a sealed suction wound care system are performed every one to three days depending on the amount of exudate produced by the wound. The computerized vacuum pump is rented on a monthly basis. An RN is required to perform a sealed suction wound care system dressing change.

Use the procedure codes L-E2402 and 9-A6550 for a sealed suction wound care system and associated supplies.

24.5.14.5 Pulsatile Jet Irrigation Wound Care System

A pulsatile jet irrigation wound care system consists of a pistol-style hand piece with a trigger to control the pulsatile jet. A suction pump is used to remove the fluid. The wound is then dressed using standard wound care supplies.

Dressing changes associated with a pulsatile jet irrigation wound care system are performed every one to three days depending on the amount of exudate produced by the wound. An RN is required to perform a pulsatile jet irrigation wound care system dressing change.

Use procedure code L-E1399 for a pulsatile jet irrigation wound care system.

24.5.14.6 Wound Care System 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.

24.5.14.7 Prior Authorization

To request prior authorization for a wound system, the documentation listed below must be provided on the Statement of Initial Wound Therapy System In-Home Use Form on page B-91 for an initial or recertification request and 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.

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.

24.5.14.8 Wound Care Procedures and Limitations

Procedure Code	Maximum Limitation
9-A4213	As needed
9-A4217	As needed
9-A4244	1 per month
9-A4245	Per box as needed
9-A4246	1 per month
9-A4247	1 per month
9-A4450	20 per month
9-A4452	20 per month
9-A4455	4 per month
9-A4461	As needed
9-A4930	As needed
9-A6000	15 per month
9-A6010	As needed
9-A6011	As needed
9-A6021	As needed
9-A6022	As needed
9-A6023	As needed
9-A6024	As needed
9-A6025	As needed
9-A6154	As needed
9-A6196	As needed
9-A6197	As needed
9-A6198	As needed
9-A6199	As needed
9-A6200	As needed
9-A6201	As needed
9-A6202	As needed
9-A6203	As needed
9-A6204	As needed
9-A6205	As needed
9-A6206	As needed
9-A6207	As needed
9-A6208	As needed
9-A6209	As needed
9-A6210	As needed
9-A6211	As needed
9-A6212	As needed
9-A6213	As needed
9-A6214	As needed
9-A6215	As needed
9-A6216	As needed
9-A6217	As needed
9-A6218	As needed
9-A6219	As needed
9-A6220	As needed
9-A6221	As needed
9-A6222	As needed
9-A6223	As needed
9-A6224	As needed
9-A6228	As needed
9-A6229	As needed
9-A6230	As needed
9-A6231	As needed
9-A6232	As needed
9-A6233	As needed
9-A6234	As needed
9-A6235	As needed
9-A6236	As needed
9-A6237	As needed
9-A6238	As needed
9-A6239	As needed
9-A6240	As needed
9-A6241	As needed
9-A6242	As needed
9-A6243	As needed
9-A6244	As needed
9-A6245	As needed
9-A6246	As needed
9-A6247	As needed
9-A6248	As needed
9-A6251	As needed
9-A6252	As needed
9-A6253	As needed
9-A6254	As needed
9-A6255	As needed
9-A6256	As needed
9-A6257	As needed
9-A6258	As needed
9-A6259	As needed
9-A6260	As needed
9-A6261	As needed
9-A6262	As needed
9-A6266	As needed
9-A6402	As needed

Procedure Code	Maximum Limitation
9-A6403	As needed
9-A6404	As needed
9-A6407	As needed
9-A6410	As needed
9-A6411	As needed
9-A6412	As needed
9-A6441	As needed
9-A6442	As needed
9-A6443	As needed
9-A6444	As needed
9-A6445	As needed
9-A6446	As needed
9-A6447	As needed
9-A6448	As needed
9-A6449	As needed
9-A6450	As needed
9-A6451	As needed
9-A6452	As needed
9-A6453	As needed
9-A6454	As needed
9-A6455	As needed
9-A6456	As needed
9-A4657	As needed
9-A6550	15 per month
9-T1999	As needed
L-E0231	1 per month
L-E0232	1 per month
L-E1399	1 per month (for use with Pulsatile Jet Irrigation Wound Care System)
L-E2402	1 per month

24.5.15 Durable Medical Equipment (DME) and Supplies

The Texas Medicaid Program 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 the Texas Medicaid Program. DME benefits of the Texas Medicaid Program must have either a well-established history of efficacy or, in the case of novel or unique equipment, valid, peer-reviewed evidence that the equipment corrects or ameliorates a covered medical condition or functional disability.

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 younger than 21 years of age through Home Health Services, these services may be covered through THSteps-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 must be met.
- The equipment requested must be medically necessary, and federal financial participation must be available.
- The client's health status would be compromised without the requested equipment.
- 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.

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 must be current, unaltered, original, and handwritten. Computerized or stamped signatures 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 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 signature must be maintained by the prescribing physician.

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

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.

Obtain authorization within *three business days* of providing the service by calling TMHP Home Health Services 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.

The provider must have the client sign the DME Certification and Receipt Form on page B-35 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 also requires the name of the item and the date the client received the DME. The DME supplier should retain this form, not submit it with the claim.

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 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 THSteps-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.
- 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.
- If a DME/ medical supply provider is unable to deliver an 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 addressed are reimbursed at a maximum fee determined by HHSC. If an item is manually priced, the MSRP must be submitted for consideration of rental or purchase with the appropriate procedure codes. Purchases and rentals are reimbursed at the MSRP minus a discount as determined by HHSC.

DME is anticipated to last a minimum of five years and may be considered for replacement when five years have passed and the equipment is no longer functional and repairable. The DME may then be considered for prior authorization. Replacement of equipment will be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, with the measures to be taken to prevent reoccurrence, must be submitted.

Replacement, adjustments, modifications, or repairs will not be authorized in situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver. A referral to the DSHS Medical Case Management Department will be made by TMHP Home Health Services Prior Authorization Department (or CCP Department, where appropriate) for clients younger than 21 years of age. Providers will be notified that the state will be monitoring this client's services.

Prior authorization is required for replacement. Replacement will be considered in at least one of the following situations:

- After the maximum limitation time has elapsed and the DME is no longer functional and/ or repairable.
- When irreparable damage has occurred.

Documentation, which must accompany a request, includes a statement from the prescribing physician, which includes:

- A copy of the fire or police report.
- The cause of the loss or damage and what measures will be taken to prevent reoccurrence.

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 to consider. The STAR+PLUS health plan is not responsible for these services.

Cancelling an 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.

Repairs

Repairs will not be 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.

Benefits of the Home Health Services Program such as medical equipment (rental, purchase, or repairs) includes, but is not limited to:

- Manual or powered wheelchairs: *noncustomized,* including medically justified seating, supports, and equipment, or *customized,* specifically tailored or individualized, wheelchairs, including appropriate medically justified seating, supports, and equipment not to exceed an amount specified by HHSC.

Example: *If a wheelchair is requested, the provider should define additional items needed, such as foot rests or crutch holders, removable arms, or special attachments.*

- Canes, crutches, walkers, and trapeze bars.
- Bed pans, urinals, bedside commode chairs, elevated commode seats, bath chairs/ benches/ seats, and bath tub rails that are not wall-mounted.
- Electric and nonelectric hospital beds, mattresses, and bed-side rails.
- Air flotation or air pressure mattresses and cushions.
- Reasonable and appropriate appliances for measuring blood pressure and blood glucose suitable to the client's medical situation to include replacement parts and supplies.

- Freestanding lifts for assisting the client to ambulate within their residence or to transfer the client from one piece of equipment to another.
- Pumps for feeding tubes and IV administration.
- Respiratory or oxygen-related equipment.

Payment may be 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.

Refer to: "Physician Supervision—Plan of Care" on page 24-7.

"DME Certification and Receipt Form" on page B-35.

"Home Health Services Plan of Care (POC)" on page B-47.

"Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)" on page B-42 and

"Addendum to Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form" on page B-45.

"Procedure Codes That Do Not Require Prior Authorization" on page 24-67 for equipment that does not require prior authorization.

"Provider Enrollment" on page 1-2.

24.5.16 Augmentative Communication Device (ACD) System

ACD systems are a benefit of Home Health Services and require prior authorization. ACD systems for clients younger than 21 years of age who do not meet the criteria for home health services may be considered under THSteps-CCP.

Refer to: "ACD Procedure Codes and Limitations" on page 24-36 for more information.

24.5.16.1 ACD Systems

An ACD system, also known as an augmentative and alternative communication (AAC) device system, allows a client to overcome the disabling effects of severe communication impairment by representation of vocabulary or ideas and expression of messages and enables the client to meet their functional speaking needs. For the purpose of this policy, the term "ACD system" refers to the ACD and all medically necessary components and accessories. Permanent loss of speech is defined as a severe communication disorder with no functional means/intelligible sound to communicate basic needs or thoughts.

An ACD system is a benefit of the Texas Medicaid Program and may be considered for prior authorization as a Home Health Services benefit when the following home health services eligibility criteria are met:

- The client must be eligible for home health benefits.
- The criteria in this section must be met.
- The equipment requested must be medically necessary.
- The client's status would be compromised without the requested equipment.
- Federal financial participation must be available.
- The requested equipment or supplies must be safe for use in the home.

24.5.16.2 Prior Authorization and Required Documentation

Prior authorization is required for rental or purchase of an ACD system provided through Home Health Services. The prior authorization request should include all related accessories and/or supplies.

Before requesting prior authorization, 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. All signatures and dates must be current, original, unaltered, and handwritten. Computerized or stamped signatures will not be accepted. The date of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form can be no more than three months before the service start date. Forms that are submitted more than three months before the start of service will result in an authorization rejection. A letter will be generated to the provider stating that the date of the Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form is prior to the three-month limit. The completed, signed, and dated Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must include the procedure codes and quantities for services requested and must be maintained by the DME provider and the prescribing physician in the client's medical record.

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

- Diagnosis/condition causing impairment of communication.
- Accurate diagnostic information pertaining to any other medical diagnoses/conditions, to include the client's overall health status.

The following documentation must be submitted with the completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form:

- The physician familiar with the client will base his/her recommendation on the review of a formal written evaluation of cognitive and language abilities

completed by a speech language pathologist (SLP). The prior authorization criteria must be addressed in this evaluation. The prescribing physician will review the professional evaluation/assessment and base the prescription on the recommendations.

- The formal written ACD system evaluation completed, signed, and dated by a speech-language pathologist (SLP) must include a minimum of all of the following information:
  - Current communication impairment, including the type, severity, language skills, cognitive ability and anticipated course of the impairment.
  - A description of the functional communication goals expected to be achieved and treatment options, including the ability of the requested ACD system, accessories and/or software to meet the projected communication needs of the client, and the length of time it is expected to meet their needs (must be anticipated to meet the client's needs for a minimum of 5 years).
  - Anticipated changes, modifications or upgrades that will be needed to meet the future needs (up to 5 years) of the client, to include projected long and short term time frames.
  - A treatment plan that includes a training schedule for the selected device and components addressing the needs of the client and caregiver to ensure appropriateness and optimal use of the prescribed device.
  - Evaluation that the client possesses the cognitive, emotional and physical abilities to effectively use the selected device and any accessories to communicate, including cognitive, postural, mobility and sensory (visual and auditory) capabilities.
  - Evaluation of the residential, vocational, educational and other settings/situations requiring communication (e.g., transportation), alternative ACD system evaluated, with a consideration of the advantages/disadvantages of the device considered as well as their appropriateness for the client.
  - How the use of the ACD system will be implemented/integrated into various environments of use.
  - Medical status/condition and medical diagnosis that is underlying the severe expressive speech disability leading to the need for an ACD system.
  - An assessment of the client's daily communication needs and whether they could be met using other natural modes of communication.
  - Other forms of treatment that have been considered and ruled out.
  - The rationale for selection of a specific device and any accessories, including why the requested equipment is the most appropriate and cost effective for the particular client, and that the client's speech disability will benefit from the device ordered.

Note: *The Texas Medicaid Program may request additional information to clarify or complete a request for an ACD system and accessories.*

The SLP evaluation must be dated before the date on the physician's prescription (Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form).

An ACD system is expected to serve the client's needs for an extended period of time. Refer to "Replacement" on page 24-35 for additional information.

24.5.16.3 Procedure Codes for ACD Systems and Accessories

ACDs and Access Devices

A *digitized speech device*, sometimes referred to as a "whole message" speech output device, utilizes words or phrases that have been recorded by someone other than the ACD system user for playback upon command of the ACD system user. Use procedure codes J/L-E2500, J/L-E2502, J/L-E2504, and J/L-E2506 for the rental or purchase of a digitized speech device.

A *synthesized speech device* is a technology that translates a user's input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech ACD systems are not limited to pre-recorded messages, but can independently create messages as their communication needs dictate.

Some synthesized speech devices require that the user make *physical contact* with a keyboard, touch screen, or other display containing letters. Use procedure code J/L-E2508 for the rental or purchase of a synthesized speech device.

Other synthesized devices allow multiple methods of message formulation through letters, words, pictures, or symbols. Such devices also allow for multiple methods of access including direct physical contact with a keyboard or touch screen; and one or more tools that aid in direct selection, including joystick, head mouse, optical pointer, infrared and light pointers, scanning device, or morse code. These synthesized speech devices are reimbursed with procedure code J/L-E2510.

Synthesized speech language generating devices with *multiple* methods of message formulation and *multiple* methods of device access are reimbursed with procedure code J/L-E2510 and the corresponding modifier TG (Intermediate level) or TF (Complex/High tech level) as indicated below.

Reimbursement for the rental or purchase of synthesized speech generating devices that have multiple methods of message formulation and multiple methods of device access may be considered based on the following levels of access devices:

- Minimum level—basic access device, such as a joystick for clients with good gross and fine motor control (no modifier required).

- Medium level—gross motor control access devices, such as a switch or large button, for clients with good gross motor skills, but poor fine motor extremity skills (use modifier TF).
- Maximum level—fine motor and head control access devices, such as a laser or infrared pointer, for clients with good fine motor head control, but poor fine and gross motor extremity skills (use modifier TG).

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).
  - 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 owned laptop PC or PDA, an ACD system will be considered for prior authorization instead of the ACD software.
  - If software is purchased, installation of the program and technical support are included in the reimbursement for the software. Rental of ACD system software is not a benefit. Speech generating software is identified with procedure code J-E2511.

  Note: *Either an ACD system or ACD software for a client-owned laptop or desktop PC or PDA may be authorized, but not both.*
- Batteries.
- Battery charger, power supplies, A/C, and/or other adapters.
- Interface cables.
- Adequate memory to allow for system expansion within a five year time frame.
- All basic operational training necessary to instruct the client and family/caregiver(s) in the use of the ACD system.
- Manufacturer's warranty.
- Interconnects.
- Sensors.
- Moisture guard.
- Access device when necessary.
- Mounting device when necessary.

24.5.16.4 ACD System Accessories

Accessories for rental or purchase are a benefit of Home Health Services if the criteria for ACD system authorization are met *and* the medical necessity of *each* accessory is clearly documented in the SLP written evaluation.

All accessories necessary for proper use of an ACD system, including those necessary for the potential growth/expansion of the ACD system (such as a memory card), should be included in the initial prescription for purchase.

The following accessories may be considered for reimbursement if the criteria for ACD system authorization are met *and* the medical necessity for *each* accessory is clearly documented in the written evaluation:

- Access devices for an ACD system include, but are not limited to, devices that enable selection of letters, words or symbols via direct selection or tools that aid in direct 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 head and hand 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.
- Moisture guard.
- Extended warranty if cost beneficial.

Use procedure code J/L-E2599 when billing for accessories for speech generating devices.

Mounting systems are devices necessary to place the ACD system, switches and other access devices within the reach of the client. Mounting devices may be considered to attach an ACD system or access device to a wheelchair or table. The make, model, and purchase date of the wheelchair or table is required when requesting a wheelchair mounting device. One additional mounting device, separate form the one included in the system, may be considered for prior authorization for the same client. Use procedure code J/L-E2512 when billing for the rental or purchase of mounting systems when a second mount is medically necessary.

24.5.16.5 Noncovered ACD System Items

Items that are not related to the ACD system, or software components which are not necessary to operate the system, are not a benefit of the Texas Medicaid Program. These items include, but are not limited, to carrying cases and printers.

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

24.5.16.6 Prior Authorization

All of the following criteria must be met in order to consider prior authorization of an ACD system. These criteria must be addressed in the written evaluation. The client must have:

- A severe communication disorder with no functional means/intelligible sound to communicate basic needs or thoughts.

- A minimum mental or developmental age of 24 months.
- The ability to see, hear, and feel sensation.
- The ability to follow two-step commands, take turns, and initiate an interaction.
- The ability to demonstrate performance, attention, desire, interest, flexibility, and independence.
- An understanding of cause and effect and object permanence.
- Someone available to communicate with or a situation to communicate in.
- A family/ caregiver(s) willing to support the client in the use of the ACD system.

24.5.16.7 Trial Period/ Rental/ Purchase

In order to ensure and ascertain that the client's needs are met in the most cost effective manner, an ACD system will not routinely be prior authorized for purchase until the client has completed a 6-month trial period that included experience with the requested system. Prior authorization may be provided for rental during this trial period. All components, such as access devices, mounting devices and lap trays necessary for use, must be evaluated during this trial period.

In the situation where an ACD system is not available for rental, purchase can be considered with documentation that the client has had experience with the requested system at school or in another setting.

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.

To obtain prior authorization for ACD system rental, all of the following documentation must be submitted:

- A formal written evaluation completed by an SLP before requesting an ACD system rental.
- 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, and dated by the physician.

Purchase

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

- A formal written evaluation/ re-evaluation must be completed by an SLP before requesting an ACD system purchase. The evaluation/ re-evaluation must include documentation that the client has had sufficient experience with the requested ACD system through trial/ rental, school, or another setting.
- 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 and dated by the physician.

24.5.16.8 DME Certification

The signed and dated DME certification and Receipt Form is required and must be completed before reimbursement can be made for any DME delivered to a client. The certification form must include the date the client received the DME, the item(s) name, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's record.

24.5.16.9 Reimbursement

Items and/ or services addressed in this section are either reimbursed at a maximum fee determined by HHSC or through manual pricing. If an item is manually priced, the MSRP must be submitted for consideration of rental or purchase with the appropriate procedure codes. Purchases are reimbursed at MSRP minus a discount as determined by HHSC.

24.5.16.10 Nonwarranty Repairs

Nonwarranty repairs of an ACD system may be considered for prior authorization with documentation from the manufacturer explaining why the repair is not covered by the warranty. A request for prior authorization of ACD system repair(s) not covered by warranty must be submitted with the following procedure codes. Use procedure code 9-E1340 for non-warranty repairs. Use procedure code 9-A9900 for nonwarranty parts.

24.5.16.11 Replacement

An ACD system is anticipated to last a minimum of five years. Documentation must be submitted for the following situations:

- If requesting a replacement with the same ACD system or repair of the present ACD system, a statement must be submitted indicating that the client's abilities and/ or communication needs are unchanged and/ or no other currently available ACD system is better able to meet the client's needs.
- If requesting a different ACD system from the one lost or damaged, a new evaluation/ assessment is required.
- When appropriate, a copy of the police or fire report listing the cause of the loss or damage, as well as, what measures will be taken to prevent reoccurrence.
- In situations where the equipment has been abused or neglected by the client, the client's family, or the caregivers, the Home Health Services Prior Authorization Department will make a referral to the DSHS THSteps Case Management Program for clients under 21 years of age. The provider will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Prior authorization for replacement may be considered within five years or more from the purchase date or when the ACD system is no longer functional, and either cannot be repaired or it is not cost effective to repair.

Note: *ACD system replacements for clients under 21 years of age that do not meet the criteria in this section may be considered through THSteps-CCP.*

24.5.16.12 ACD Procedure Codes and Limitations

Procedure Code	Maximum Limitation
9-E1340	As needed, with documentation of warranty coverage
J-E2500	1 per 5 years
J-E2502	1 per 5 years
J-E2504	1 per 5 years
J-E2506	1 per 5 years
J-E2508	1 per 5 years
J-E2510	1 per 5 years
J-E2510-TF	1 per 5 years
J-E2510-TG	1 per 5 years
J-E2511	1 per 5 years
J-E2512	1 per 5 years
J-E2599	1 per 5 years
L-E2500	1 per month
L-E2502	1 per month
L-E2504	1 per month
L-E2506	1 per month
L-E2508	1 per month
L-E2510	1 per month
L-E2510-TF	1 per month
L-E2510-TG	1 per month
L-E2512	1 per month
L-E2599	As needed, with documentation of warranty coverage

24.5.17 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.

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

The following criteria must be met to qualify for Home Health Services:

- The requested equipment must be medically necessary.
- The client must be eligible for home health benefits.
- The criteria listed in this policy for the requested supplies/equipment must be met.
- Federal financial participation must be available.
- The requested equipment must be safe to use in the home.

Bath seats are not considered for clients younger than one year of age or weighing less than 30 pounds. 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. To request prior authorization for bath or bathroom equipment, the following documentation must be provided:

- Diagnosis/condition.
- 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.

A completed, signed, and dated 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 prescribing physician who is familiar with the client before requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form must be maintained by the DME provider and prescribing physician in the client's record. The original signature must be maintained in the client's record.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of the medical necessity of the requested equipment and/or supplies. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the bath or bathroom equipment.

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.

Hand-Held Shower/ Shower Wand

A hand held shower/ shower wand is a shower head attached to a flexible tubing. Hand held showers/ shower wands with attachments are limited to one every five years.

A hand-held shower/ shower wand with attachments may be considered for prior authorization only if the client currently owns or meets the criteria for a bath/ shower chair, tub stool/ bench, or tub transfer bench. Prior authorization of a hand-held shower/ shower wand includes all attachments and accessories.

Use procedure code J-E1399 when billing for a hand held shower/ shower wand.

Hand held showers/ shower wands with attachments are limited to one every five years.

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.

A bath/ shower chair is a stationary or mobile seat with or without upper body/ head support used to support a client who is unable to stand or sit independently in the shower or tub.

A tub stool/ bench is a stationary seat/ bench used to support a client who is unable to stand or sit independently in the shower or tub.

A tub transfer bench is a stationary bench that sits in the tub and extends outside the tub used to support a client who is unable to stand or sit independently in the shower or tub to sit and allows the client to scoot/ slide over the side of the tub.

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).

Use procedure code J-E0240 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. Use procedure code J-E0240 with modifier TF (Intermediate Level) 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 requires trunk and/ or head/ neck support or positioning to accommodate conditions that include, but are 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. A custom bath/ shower chair may be considered for reimbursement only if the client does not also have any type of commode chair. Use procedure code J-E0240 with the TG modifier (Complex/ high level) 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. Use procedure code J-E0245 for a tub/ stool bench. Use procedure code J-E0247 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. Use procedure code J-E0248 for a heavy duty tub transfer bench.

Bathroom Equipment

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

Non-fixed toilet rails sit on the floor and attach to the commode to allow support while sitting/ standing during use of the toilet. Non-fixed toilet rails are limited to two every five years.

A bathtub rail attachment is a rail that screws onto the side of the tub to provide support while climbing into or out of the tub. Bathtub rails are limited to one every five years.

A raised toilet seat is a device that adds height to the toilet seat. It is either fixed height or adjustable and is either attached to the toilet or is resting on the bowl. Raised toilet seats are limited to one every five years.

Non-fixed 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.

Use procedure code J-E0243, J-E0244, or J-E0246 for non-fixed toilet rails, bathtub rails or raised toilet seats.

Portable Sitz Bath

Portable sitz bath is used to immerse only the perineum and buttocks, that fits over commode seats. 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.

Use procedure codes J-E0160 or J-E0161 for portable sitz baths.

Bath Lifts

A bath lift is a client lift for use in the bathroom designed to accommodate the smaller space. 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 rails.
- 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.

Use procedure code J/ L-E0625 for the purchase or rental of bath lifts.

The purchase of a lift sling is limited to one every five years. Use procedure code J-E0621 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
J-E0160	2 per year
J-E0161	2 per year
J-E0240	1 every 5 years
J-E0243	2 every 5 years
J-E0244	1 every 5 years
J-E0245	1 every 5 years
J-E0246	1 every 5 years
J-E0247	1 every 5 years
J-E0248	1 every 5 years
J-E0621	1 per year
J-E0625	1 every 5 years
J-E0630	1 every 5 years
J-E1399	1 every 5 years
L-E0625	1 per month

Bath and bathroom equipment that have been purchased are anticipated to last a minimum of five years and may be considered for replacement when five years have passed and/ or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a recurrence must be submitted.

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 all projected changes in the clients mobility needs, the date of purchase, the 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.

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.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management Department will be made by the Home Health Services Prior Authorization Department for clients under 21 years of age. Providers will be notified that the state will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

Accessories

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

24.5.18 Blood Pressure Devices

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

- Medically necessary and appropriate.
- 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 use procedure codes 9-A4660 and 9-A4670

If the client is not eligible for home health services, blood pressure devices may be provided under THSteps-CCP for clients younger than 21 years of age.

Prior authorization is required for blood pressure devices. Electronic blood pressure devices are not a benefit through Home Health Services. Rental of electronic blood pressure devices may be prior authorized through THSteps-CCP for clients *younger than 12 months of age*.

Refer to: "Electronic Blood Pressure Monitoring Device" on page 43-53 for more information.

24.5.19 Breast Pumps

A breast pump is a benefit of Title XIX Home Health Services and requires prior authorization.

A manual 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. Use procedure codes J-E0602 or J-E0603 for the purchase of a manual or electronic breast pump.

An electric breast pump may be considered for purchase only with appropriate documentation supporting medical necessity and an explanation of why a manual breast pump was not effective. Supporting documentation may include an evaluation from a lactation consultant or RN, such as an experienced perinatal nurse.

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.

Procedure code J/L-E0604 for a hospital grade breast pump is not a benefit of Home Health Services.

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

24.5.20 Continuous Passive Motion (CPM) Device

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.

A CPM device is reimbursed on a daily basis and is limited to once per day. Reimbursement includes delivery, set-up and all supplies. Use procedure code L-E0935 when billing for a CPM machine.

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

24.5.21 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		
9-A4206	9-A4207	9-A4208
9-A4209	9-A4212	9-A4222
9-A4245	9-A4247	9-A4300
9-A4305	9-A4306	9-A4450
9-A4452	9-A4930	9-A6206
9-A6207	9-A6257	9-A6258
9-A6402	9-A9900	9-S1015

Procedure Code		
J/L-E0776	J/L-E0779	J/L-E0780
J/L-E0781	J/L-E0791	

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.

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.

An IV infusion pump that has been purchased is anticipated to last a maximum of 5 years and may be considered for replacement when 5 years have passed and/or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent a reoccurrence must be submitted.

A completed Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form that prescribes the DME and/or medical supplies must be signed and dated by a prescribing physician who is familiar with the client before requesting authorization. All signatures must be current, unaltered, original, and handwritten. Computerized or stamped signatures will not be accepted. The completed, signed, and dated Home Health DME Prior Authorization Form must be maintained by the requesting provider and the prescribing physician. The original signature copy must be kept in the physician's medical record for the client.

To avoid unnecessary denials, the physician must provide correct and complete information, including documentation of the medical necessity of the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record. The requesting provider may be asked for additional information to clarify or complete a request for the IV therapy equipment and supplies.

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 being administered, the duration of drug therapy, and the frequency of administration.

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:
  - Non-sterile 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.

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: *Non-sterile/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 are electrical devices without a battery, or with a battery that requires frequent recharging (more frequently than every 4 hours), used to deliver an intravenous solution or parenteral drugs at a steady flow rate. 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 are electrical devices that have an extended battery life (four hours or longer without recharging) used to deliver an intravenous solution or

parenteral drugs at a steady flow rate. 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 are non-electrical, single use, simplified devices that deliver parenteral drugs at a fixed volume and flow rate. Elastomeric infusion pumps may be a benefit for short-term use when the caregiver cannot administer the infusion via pump. Dial flow regulators, such as dial-a-flow, are incorporated into IV extension sets or IV tubing. They are non-electrical, single use, simplified devices that deliver parenteral drugs at a fixed volume and flow rate utilizing a dial system to set a flow rate.

If additional supplies are needed beyond the standards listed in this policy, 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:
  - 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:
  - Phlebitis.
  - Infiltration.
  - Extravasation.
- For more frequent IV tubing or add-on changes, supporting documentation should have evidence that includes, but is not limited to:
  - Phlebitis.
  - IV catheter-related infection.
  - The administered infusion requires more frequent tubing changes.

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 pump rental/ tubing
- The caregiver can not administer infusion via pump

Elastomeric devices may be reimbursed using procedure codes 9-A4305 and 9-A4306.

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.

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.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management Department will be made by the Home Health Services Prior Authorization Department for clients under 21 years of age. Providers will be notified that the state will be monitoring the client's services to evaluate the safety of the environment for both the client and the equipment.

The completed, signed, and dated DME Certification and Receipt Form is required before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's medical record.

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

24.5.22 Phototherapy Devices

Phototherapy devices for use in the home are a benefit of the Texas Medicaid Program for low-risk infants. Medium- to high-risk infants, as defined by the American Academy of Pediatrics (AAP), should be considered for other, more extensive treatment in an inpatient setting. Home phototherapy devices use light exposure with white, blue, or green lights to increase bilirubin excretion in the infant with elevated bilirubin levels. Home phototherapy services include parent/guardian education and obtaining laboratory specimens. Laboratories performing analysis of laboratory specimens may bill according to established procedures. Home phototherapy must be prior authorized under a provider identifier that is enrolled as a DME supplier. Home phototherapy devices require prior authorization and are provided only for the days that are medically necessary. Consideration for the rental of a home phototherapy device includes, but is not limited to, the following primary diagnoses:

Diagnosis Codes				
7740	7741	7742	77430	77431
77439	7744	7745	7746	7747

Authorization requirements include following the current guidelines and standards set by the AAP:

Indications for phototherapy in the home for infants 35 weeks gestation or greater				
	0-24 hours	25-48 hours	49-72 hours	>72 hours
Low Risk	6-10	10-16	13-18	16-21

Note: *Bilirubin levels are expressed in mg/dl*

- Lower risk infants are greater than or equal to 38 weeks gestation and well.
- Risk factors may include but are not limited to isoimmune hemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temperature instability, sepsis, acidosis, or albumin <3.0 g/dl (if measured).

Documentation of medical necessity is required if the infant does not meet authorization requirements. Documentation of medical necessity includes:

- Serum bilirubin level (in mg/dl).
- Gestational age.
- Any known risk factors (for example: breast feeding, jaundice within the first 24 hours, blood group incompatibility).
- Physician's POC for intervention after seven days.
- Anticipated number of days the client will need the phototherapy light.
- Documentation of parental education regarding the importance of monitoring and follow-up.

Note: *The total serum bilirubin levels listed are guides for authorization only.*

Prior authorization may be given up to a maximum of seven days at a time with the documentation of medical necessity that is listed above. A new prior authorization is required for requests beyond seven days.

Home phototherapy devices will not be considered for prior authorization if the client has an open authorization for skilled nursing visits to address hyperbilirubenemia.

In accordance with AAP guidelines, the Texas Medicaid Program expects that there will be an ongoing assessment for risk of severe hyperbilirubenemia for all infants who receive home phototherapy.

Retroactive Eligibility

Newborn babies may not have a Medicaid number at the time that services are ordered by the physician and provided by the supplier. In these cases, authorization may be given retroactively for services rendered between the start date and the date that the client's Medicaid number becomes available.

- The provider is responsible for finding out the effective dates of client eligibility.
- The provider has 95 days from the date on which the client's Medicaid number becomes available (add date) to obtain authorization for services that were already rendered.

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

Rental of a phototherapy device is reimbursed as a daily global fee. The global fee includes skilled nursing visits (SNV) for client teaching, monitoring, and customary and routine laboratory work.

The SNV will be denied as part of the phototherapy device rental.

Note: *Providers may* not *bill for those days the phototherapy device is at the client's home and is* not *in use.*

Use procedure code L-E0202 for home phototherapy devices.

Note: *Services provided after the client's Medicaid number is available must be prior authorized within three business days.*

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

Refer to: Section 24.3.1, "Eligibility."

24.5.23 Hospital Beds and Equipment

Hospital beds are defined as medical beds that are used by a client who has a medical condition that requires positioning the body in ways that are not feasible with an ordinary bed. 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 THSteps-CCP for clients younger than 21 years of age.*

Hospital beds require prior authorization.

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

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 this policy:

- 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.
- Heavy-duty hospital beds:
  - A heavy-duty, extra wide hospital bed is capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds *or*
  - A extra heavy-duty, extra wide hospital bed is 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 *fixed height bed* 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.

Use procedure code J/L-E0250 when billing for a fixed height bed.

A *variable height hospital bed* 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.

Use procedure code J/L-E0255 when billing for a variable height hospital bed.

A *semi-electric hospital bed* 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.

Use procedure code J/L-E0260 when billing for a semi-electric hospital bed.

A *fully electric hospital bed* 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 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 authorized for the convenience of the caregiver.

Use procedure code J/L-E0265 when billing for a fully electric hospital bed.

A *heavy-duty, extra wide hospital bed* is capable of supporting a client who weighs more than 350 pounds, but no more than 600 pounds. 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.

Use procedure code J/L-E0303 when billing for a heavy-duty, extra wide hospital bed.

An *extra heavy-duty, extra wide hospital bed* is capable of supporting a client who weighs more than 600 pounds. 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.

Use procedure code J/L-E0304 when billing for an extra heavy-duty, extra wide hospital bed.

Equipment

All equipment must be prior authorized.

A *trapeze bar attached to a bed* 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. Use procedure code J/L-E0910 or J/L-E0911 when billing for a trapeze bar attached to a bed.

Free standing trapeze equipment 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. Use procedure codes J/L-E0912 or J/L-E0940 when billing for free standing trapeze equipment.

An *over-bed table* may be considered for reimbursement if client is bed bound and needs the equipment for treatments. Use procedure code J-E0315 when billing for an over-bed table.

A safety enclosure (J/L-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 THSteps-CCP.

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

Pressure-Reducing Support Surfaces

Pressure-reducing support surfaces must be prior authorized.

A pressure-reducing support surface includes three separate groups of mattress/mattress-like equipment designed to assist in the healing of wounds. These devices are used in conjunction with conventional wound care therapy and/or to prevent the occurrence of said wounds in susceptible clients. Pressure-reducing support surfaces are designed to prevent skin breakdown or promote the healing of pressure ulcers by reducing or eliminating tissue interface pressure. Most of these devices reduce interface pressure by conforming to the contours of the body so that pressure is distributed over a larger surface area rather than concentrated on a more circumscribed location.

Pressure-reducing support surfaces are a benefit of Home Health Services on a case-by-case basis. 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, stasis, or degradation).
- Current wound therapy if any.
- Wound measurements to include location, length, width, depth, any undermining and/or tunneling, and odor if applicable.

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 pressure-reducing support surface policy 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.

24.5.23.1 Criteria for Grouping Levels

Group 1 Support Surfaces

A group 1 Support Surface may be considered if the client is completely immobile without assistance, *or* either of the following first two criteria:

- The client has limited mobility, *or*
- The client has an existing pressure ulcer on the pelvis or trunk, *and*

And at least one of these four criteria:

- 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 for mattresses/nonpowered pressure-reducing mattress overlays are designed to be placed on top of a standard hospital or home mattress. 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 are designed to be placed directly on a hospital bed frame. 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.

Powered pressure-reducing mattress overlay systems (alternating pressure or low air loss) are designed to be placed on top of a standard hospital or home mattress. 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.
- The manufacturer's product information substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces.

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.

Powered pressure-reducing mattress (alternating pressure low air loss, or powered flotation without air loss) is designed to be placed directly on a hospital bed frame. This 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.

An *advanced nonpowered pressure-reducing mattress overlay* is designed to be placed on top of a standard hospital or home mattress. This 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.
- The manufacture product information substantiates that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces.

A *powered pressure-reducing mattress overlay* (low air loss, powered flotation without low air loss, or alternating pressure) is designed to be placed on top of a standard hospital or home mattress designed to reduce friction and shear. This 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 overlay.
- Inflated cell height of the air cells through which air is being circulated is 3.5 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 to provide adequate client lift, reduce pressure and prevent bottoming out.

An *advanced nonpowered pressure-reducing mattress* is designed to be placed directly on a hospital bed frame. This 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 than a Group 1 mattress and prevent bottoming out.
- Total height of five 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).

Group 3 Support Surfaces

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

- 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 and 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.

The groups for pressure-reducing support surfaces used in this policy are defined as follows.

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.

An *air-fluidized bed* uses warm air under pressure to set small ceramic beads in motion, which simulate the movement of fluid. When the client is placed in the bed, the client's body weight is evenly distributed over a large surface area, which creates the sensation of floating. Air-fluidized beds may be considered for reimbursement when the medical necessity criteria for Group 3 support surfaces are met.

24.5.23.2 Decubitus Care Accessories

A bed blanket cradle (keeps bed covers from touching affected skin) 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 used in this policy 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.

Bed rails and frames that have been purchased are anticipated to last a minimum of 5 years and may be considered for replacement when 5 years have passed and/or the equipment is no longer functional and no longer repairable. The durable medical equipment may then be considered for prior authorization. Replacement of equipment will also be considered when loss or irreparable damage has occurred. A copy of the police or fire report when appropriate, and the measures to be taken to prevent reoccurrence must be submitted.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management unit will be made by the Home Health Services prior authorization unit for clients under 21 years of age. Providers will be notified that the State will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

24.5.23.3 Hospital Beds and Equipment Procedure Code Table

Procedure Code	Maximum Limitation
J-E0184	1 every 5 years
J-E0185	1 every 5 years
J-E0186	1 every 5 years
J-E0187	1 every 5 years
J-E0198	1 every 5 years
J-E0199	1 every 5 years
J-E0250	1 every 5 years
J-E0255	1 every 5 years
J-E0260	1 every 5 years
J-E0265	1 every 5 years
J-E0271	1 every 5 years
J-E0303	1 every 5 years
J-E0304	1 every 5 years
J-E0305	1 every 5 years
J-E0310	1 every 5 years
J-E0315	1 every 5 years
J-E0371	1 every 5 years
J-E0372	1 every 5 years
J-E0373	1 every 5 years
J-E0910	1 every 5 years
J-E0911	1 every 5 years
J-E0912	1 evert 5 years
J-E0920	1 every 5 years
J-E0940	1 every 5 years
J-E0946	1 every 5 years
L-E0184	1 per month
L-E0185	1 per month
L-E0186	1 per month
L-E0187	1 per month
L-E0193	1 per month
L-E0194	1 per month
L-E0196	1 per month
L-E0197	1 per month
L-E0198	1 per month
L-E0250	1 per month
L-E0255	1 per month
L-E0260	1 per month
L-E0265	1 per month
L-E0277	1 per month
L-E0303	1 per month
L-E0304	1 per month
L-E0371	1 per month

Procedure Code	Maximum Limitation
L-E0372	1 per month
L-E0373	1 per month
L-E0910	1 per month
L-E0911	1 per month
L-E0912	1 per month
L-E0920	1 per month
L-E0940	1 per month
L-E0946	1 per month

24.5.24 Reflux Slings and Wedges

Home Health Services may cover reflux slings or wedges for clients who are younger than 12 months of age. These may be used as positioning devices for infants who require elevation after feedings when prescribed by a physician as medically necessary and appropriate. Reflux slings, wedges, or covers require prior authorization.

If the client is not eligible for home health services, reflux slings and wedges may be provided under THSteps-CCP. Use procedure code J-E1399 when billing for reflux slings and wedges.

24.5.25 Special Needs Car Seats and Travel Restraints

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

Refer to: "Special Needs Car Seats and Travel Restraints" on page 43-57 for details about coverage through THSteps-CCP.

24.5.26 Mobility Aids

Medical appliances and equipment including mobility aids such as canes, crutches, walkers, and wheelchairs are reimbursed to assist clients to move about in their environment.

Mobility aids are a benefit through Home Health Services when the following criteria are met:

- The client must be eligible for home health benefits.
- The criteria listed in this policy for the requested equipment must be met.
- The equipment requested must be medically necessary.
- Federal financial participation must be available.
- The client's mobility status would be compromised without the requested equipment.
- The requested equipment or supplies must be safe for use in the home.

Note: *A mobility aid for a client under 21 years of age is medically necessary when it is required to correct or ameliorate a disability or physical illness or condition.*

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.

The Texas Medicaid Program does not reimburse separately for associated DME charges, including batter 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 THSteps-CCP.*

Refer to: Section 24.3.1, "Eligibility."

24.5.26.1 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.

24.5.26.2 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 THSteps-CCP or a wheelchair may be considered for reimbursement with prior authorization from TMHP Home Health Services Prior Authorization Department.

24.5.26.3 Wheelchairs

A wheelchair is a professionally manufactured seating system mounted on a four- or six-wheeled base, with a combination of tires and casters especially for the use of propelling the occupant.

A wheelchair may be considered for prior authorization for short-term use or purchase as a home health service with documentation supporting the medical necessity and appropriateness of the requested item. This documentation by a physician familiar with the client must include information on the client's impaired mobility and physical requirements.

In addition, one of 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.

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 molded seating system is limited to 15 hours or less.

Assessment of the accessibility of the client's residence must be completed and included in the prior authorization documentation to ensure that the wheelchair is usable in the home such as doors and halls wide enough, no obstructions.

24.5.26.4 Seating Assessment for Manual and Power Custom Wheelchairs

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

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 1-97001 and 1-97003.

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, which must accommodate 20 percent of height and weight changes.
- 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 authorized using the above therapy procedure codes.

24.5.26.5 Manual Wheelchairs—Custom

Standard manual wheelchairs may be prior authorized for short-term rental or for purchase, if the client has a condition which does not require specialized seating.

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

24.5.26.6 Levels for Custom Manual and Powered Wheelchairs

Level 1 is a basic standard wheelchair (no modifier required).

Level 2 is a custom system with growth potential, including 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 and space and reclining capacities (TG [Complex, high level] modifier required).

24.5.26.7 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.

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 client to understand how the power wheelchair operates.

Rental of a manual wheelchair may be prior authorized when the client's power wheelchair is being repaired or replaced.

24.5.26.8 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.

An attendant control is not a benefit of the Home Health Services.

For safety, all power chairs are to include a stop switch.

Seat lift chairs and seat elevators or mechanisms, including those used for power wheelchairs, are not a benefit of the Texas Medicaid Program

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.

An attendant control system is not a benefit of the Texas Medicaid Program. For safety, all power chairs are to include a stop switch.

Note: *Seat lift chairs, seat elevators, or mechanisms, including those used for power wheelchairs, are not a benefit of the Texas Medicaid Program.*

24.5.26.9 Scooters

A scooter is a professionally manufactured, three or four-wheeled motorized base with a professionally manufactured basic seating system for clients who have little or no positioning needs.

Scooters may be approved for a short term rental or initial three-month trial 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 such as amyotrophic lateral sclerosis.

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 wide enough, no obstructions.

All scooters must have a growth potential, which must accommodate 20 percent of height and weight changes.

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.

All documentation required for a standard power wheelchair must be provided, along with the following documentation:

- The client's physical and cognitive 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.

Custom seating for scooters is not a benefit of Home Health Services.

Repairs to scooters may be considered only for those scooters purchased by the Texas Medicaid Program.

24.5.26.10 Client Lift

A lift is a portable transfer system used to move a client from bed to chair and chair to bed.

A client lift will not be authorized for the convenience of a caregiver.

Hydraulic lifts are operated by the weight or pressure of a liquid.

Electric lifts is operated by electricity. An electric lift may be considered when a hydraulic lift will not meet the client's needs.

Barrier free lifts are not a benefit of Home Health Services.

24.5.26.11 Hydraulic Lift

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

- The client must be unable 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.

24.5.26.12 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.

24.5.26.13 Standers

A stander is a device used for the client with neuromuscular conditions who is unable to stand alone. Standers and standing programs can improve digestion, increase muscle strength, decrease contractures, increase bone density, and minimize decalcification.

Standers, including all accessories, require prior authorization.

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

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

Standers, gait trainers, and parapodiums will not be authorized for a client within one year of each other.

24.5.26.14 Gait Trainers

Gait trainers are devices with wheels used to train clients with ambulatory potential. They provide the same benefits as the stander, in addition to assisting with gait training.

Prior authorization for the 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 wheelchair is usable in the home (i.e., doors and halls wide enough, 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 THSteps-CCP will not be authorized for a client within one year of each other.

24.5.26.15 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.

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.

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.

24.5.26.16 Accessories

Accessories, modifications, adjustments, and repairs are benefits as outlined in this policy. 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.

24.5.26.17 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, 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, 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.

24.5.26.18 Adjustments

Adjustments do not require supplies. A maximum of one hour of labor for adjustments may be considered for reimbursement through Home Health Services as needed after the first six months from delivery.

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

24.5.26.19 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.

24.5.26.20 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 authorized in situations where the equipment has been abused or neglected by the client, client's family, or caregiver.

24.5.26.21 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.

Ramps may be considered for purchase for long term disabilities.

Mobility aid lifts for vehicles, and vehicle modifications are not a benefit of the Texas Medicaid Program.

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

24.5.26.22 Procedure Codes and Limitations for Mobility Aids

Procedure Code	Maximum Limit
Canes	
J-E0100	1 per 5 years
J-E0105	1 per 5 years
Crutches	
9-A4635	As needed
J-E0110	1 per 5 years
J-E0111	1 per 5 years
J-E0112	1 per 5 years
J-E0113	1 per 5 years
J-E0114	1 per 5 years
J-E0116	1 per 5 years
J-E0153	1 per 5 years
L-E0110	4 months maximum
L-E0111	4 months maximum
L-E0112	4 months maximum
L-E0113	4 months maximum
L-E0114	4 months maximum
L-E0116	4 months maximum
Walkers	
9-A4636	As needed
9-A4637	As needed
J-E0130	1 per 5 years
J-E0135	1 per 5 years
J-E0140	1 per 5 years
J-E0141	1 per 5 years
J-E0143	1 per 5 years
J-E0144	1 per 5 years
J-E0147	1 per 5 years
J-E0148	1 per 5 years
J-E0149	1 per 5 years
J-D0153	1 per 5 years
J-E0154	1 per 5 years

Procedure Code	Maximum Limit
J-E0155	1 per 5 years
J-E0157	1 per 5 years
J-E0158	1 per 5 years
J-E0159	1 per 5 years
L-E0130	4 months maximum
L-E0135	4 months maximum
L-E0141	4 months maximum
L-E0143	4 months maximum
L-E0144	4 months maximum
L-E0147	4 months maximum
L-E0148	4 months maximum
L-E0149	4 months maximum
Gait Trainers	
J-E8001	1 per day
Seating Assessments	
1-97001	As needed
1-97003	As needed
Wheelchairs	
J-E1050	1 per 5 years
J-E1060	1 per 5 years
J-E1070	1 per 5 years
J-E1083	1 per 5 years
J-E1084	1 per 5 years
J-E1085	1 per 5 years
J-E1086	1 per 5 years
J-E1087	1 per 5 years
J-E1088	1 per 5 years
J-E1089	1 per 5 years
J-E1090	1 per 5 years
J-E1093	1 per 5 years
J-E1100	1 per 5 years
J-E1110	1 per 5 years
J-E1130	1 per 5 years
J-E1140	1 per 5 years
J-E1150	1 per 5 years
J-E1160	1 per 5 years
J-E1161	1 per 5 years
J-E1170	1 per 5 years
J-E1171	1 per 5 years
J-E1172	1 per 5 years
J-E1180	1 per 5 years
J-E1190	1 per 5 years
J-E1195	1 per 5 years
J-E1200	1 per 5 years
J-E1220	1 per 5 years
J-E1220-TF	1 per 5 years
J-E1220-TG	1 per 5 years
J-E1229	1 per 5 years
J-E1231	1 per 5 years
J-E1232	1 per month
J-E1233	1 per month
J-E1234	1 per 5 years
J-E1235	1 per 5 years
J-E1236	1 per 5 years
J-E1237	1 per 5 years
J-E1238	1 per 5 years
J-E1240	1 per 5 years
J-E1250	1 per 5 years
J-E1260	1 per 5 years
J-E1270	1 per 5 years
J-E1280	1 per 5 years
L-E1050	1 per month
L-E1060	1 per month
L-E1070	1 per month
L-E1083	1 per month
L-E1084	1 per month
L-E1085	1 per month
L-E1086	1 per month
L-E1087	1 per month
L-E1088	1 per month
L-E1089	1 per month
L-E1090	1 per month
L-E1093	1 per month
L-E1100	1 per month
L-E1110	1 per month
L-E1130	1 per month
L-E1140	1 per month
L-E1150	1 per month
L-E1160	1 per month
L-E1161	1 per month
L-E1170	1 per month
L-E1171	1 per month
L-E1172	1 per month
L-E1180	1 per month
L-E1190	1 per month
L-E1195	1 per month
L-E1200	1 per month
L-E1231	1 per month
L-E1232	1 per 5 years

Procedure Code	Maximum Limit
L-E1233	1 per 5 years
L-E1234	1 per month
L-E1235	1 per month
L-E1236	1 per month
L-E1237	1 per month
L-E1238	1 per month
L-E1240	1 per month
L-E1250	1 per month
L-E1260	1 per month
L-E1270	1 per month
L-E1280	1 per month
Power Wheelchairs	
J-E1220-TF	1 per 5 years
J-E1220-TG	1 per 5 years
J-K0813	1 per 5 years
J-K0814	1 per 5 years
J-K0815	1 per 5 years
J-K0816	1 per 5 years
J-K0820	1 per 5 years
J-K0821	1 per 5 years
J-K0822	1 per 5 years
J-K0823	1 per 5 years
J-K0824	1 per 5 years
J-K0825	1 per 5 years
J-K0826	1 per 5 years
J-K0827	1 per 5 years
J-K0828	1 per 5 years
J-K0829	1 per 5 years
J-K0835	1 per 5 years
J-K0836	1 per 5 years
J-K0837	1 per 5 years
J-K0838	1 per 5 years
J-K0839	1 per 5 years
J-K0840	1 per 5 years
J-K0841	1 per 5 years
J-K0842	1 per 5 years
J-K0843	1 per 5 years
J-K0848	1 per 5 years
J-K0849	1 per 5 years
J-K0850	1 per 5 years
J-K0851	1 per 5 years
J-K0852	1 per 5 years
J-K0853	1 per 5 years
J-K0854	1 per 5 years

Procedure Code	Maximum Limit
J-K0855	1 per 5 years
J-K0856	1 per 5 years
J-K0857	1 per 5 years
J-K5058	1 per 5 years
J-K0859	1 per 5 years
J-K0860	1 per 5 years
J-K0861	1 per 5 years
J-K0862	1 per 5 years
J-K0863	1 per 5 years
J-K0864	1 per 5 years
J-K0868	1 per 5 years
J-K0869	1 per 5 years
J-K0870	1 per 5 years
J-K0871	1 per 5 years
J-K0877	1 per 5 years
J-K0878	1 per 5 years
J-K0879	1 per 5 years
J-K0880	1 per 5 years
J-K0884	1 per 5 years
J-K0885	1 per 5 years
J-K0886	1 per 5 years
J-K0890	1 per 5 years
J-K0891	1 per 5 years
J-K0898	1 per 5 years
J-K0899	1 per 5 years
L-K0813	1 per month
L-K0814	1 per month
L-K0815	1 per month
L-K0816	1 per month
L-K0820	1 per month
L-K0821	1 per month
L-K0822	1 per month
L-K0823	1 per month
L-K0824	1 per month
L-K0825	1 per month
L-K0826	1 per month
L-K0827	1 per month
L-K0828	1 per month
L-K0829	1 per month
L-K0835	1 per month
L-K0836	1 per month
L-K0837	1 per month
L-K0838	1 per month
L-K0839	1 per month

Procedure Code	Maximum Limit
L-K0840	1 per month
L-K0841	1 per month
L-K0842	1 per month
L-K0843	1 per month
L-K0848	1 per month
L-K0849	1 per month
L-K0850	1 per month
L-K0851	1 per month
L-K0852	1 per month
L-K0853	1 per month
L-K0854	1 per month
L-K0855	1 per month
L-K0856	1 per month
L-K0857	1 per month
L-K0859	1 per month
L-K0860	1 per month
L-K0861	1 per month
L-K0862	1 per month
L-K0863	1 per month
L-K0864	1 per month
L-K0868	1 per month
L-K0869	1 per month
L-K0870	1 per month
L-K0871	1 per month
L-K0877	1 per month
L-K0878	1 per month
L-K0879	1 per month
L-K0880	1 per month
L-K0884	1 per month
L-K0885	1 per month
L-K0886	1 per month
L-K0890	1 per month
L-K0891	1 per month
L-K0898	1 per month
L-K0899	1 per month
L-K5058	1 per month
Scooters	
J-E1230	1 per 5 years
J-K0800	1 per 5 years
J-K0801	1 per 5 years
J-K0802	1 per 5 years
L-E1230	1 per month
L-K0800	1 per month
L-K0801	1 per month
L-K0802	1 per month
Wheelchair Parts	
J-E0700	1 per year
9-E0705	1 per 5 years
J-E0942	1 per year
J-E0944	1 per year
J-E0945	1 per year
J-E0950	1 per year
J-E0951	2 per year
J-E0952	2 per year
J-E0955	1 per year
J-E0957	2 per year
J-E0958	1 per year
J-E0960	As needed
J-E0961	1 per year
J-E0969	1 per year
J-E0970	1 pair per year
J-E0971	1 pair per year
J-E0973	1 per year
J-E0974	1 per year
J-E0978	1 per year
J-E0980	1 per year
J-E0990	2 per year
J-E0992	1 per year
J-E0994	2 per year
J-E0995	2 per year
J-E1002	1 per 5 years
J-E1003	1 per 5 years
J-E1004	1 per 5 years
J-E1005	1 per 5 years
J-E1006	1 per 5 years
J-E1007	1 per 5 years
J-E1008	1 per 5 years
J-E1009	1 per 5 years
J-E1011	As needed
J-E1014	1 per 5 years
J-E1015	2 per year
J-E1016	2 per year
J-E1017	2 per year
J-E1018	2 per year
J-E1028	1 per 5 years
J-E1029	1 per 5 years
J-E1296	1 per 5 years
J-E1297	1 per 5 years

Procedure Code	Maximum Limit
J-E1298	1 per 5 years
J-E2201	1 per 5 years
J-E2202	1 per 5 years
J-E2203	1 per 5 years
J-E2204	1 per 5 years
J-E2205	1 per 3 years
J-E2206	1 per 3 years
J-E2207	1 per 5 years
J-E2208	1 per 5 years
J-E2209	1 per 5 years
J-E2210	1 per year
J-E2211	1 per 6 months
J-E2212	1 per 6 months
J-E2213	1 per 6 months
J-E2214	1 per 6 months
J-E2215	1 per 6 months
J-E2216	1 per 6 months
J-E2217	1 per 6 months
J-E2218	1 per 6 months
J-E2219	1 per 6 months
J-E2220	1 per 6 months
J-E2221	1 per 6 months
J-E2222	1 per 6 months
J-E2223	1 per 6 months
J-E2224	1 per 6 months
J-E2225	1 per 6 months
J-E2226	1 per year
J-E2291	1 per 3 years
J-E2292	1 per 3 years
J-E2293	1 per 3 years
J-E2294	1 per 3 years
J-E2310	1 per 5 years
J-E2311	1 per 5 years
J-E2321	1 per 5 years
J-E2323	1 per 5 years
J-E2324	1 per 5 years
J-E2325	1 per 5 years
J-E2326	1 per 5 years
J-E2327	1 per 5 years
J-E2328	1 per 5 years
J-E2329	1 per 5 years
J-E2330	1 per 5 years
J-E2340	1 per 5 years
J-E2341	1 per 5 years

Procedure Code	Maximum Limit
J-E2342	1 per 5 years
J-E2343	1 per 5 years
J-E2351	1 per 5 years
J-E2368	1 per 5 years
J-E2369	As needed
J-E2370	As needed
J-E2373	1 per 5 years
J-E2374	1 per 5 years
J-E2375	1 per 5 years
J-E2376	1 per 5 years
J-E2377	1 per 5 years
J-E2381	2 per year
J-E2382	1 pair per 5 years
J-E2383	1 pair per 5 years
J-E2384	1 pair per 5 years
J-E2385	1 pair per 5 years
J-E2386	1 pair per 5 years
J-E2387	1 pair per 5 years
J-E2388	1 pair per 5 years
J-E2389	1 pair per 5 years
J-E2390	1 pair per 5 years
J-E2391	1 pair per 5 years
J-E2392	1 pair per 5 years
J-E2393	1 pair per 5 years
J-E2394	1 pair per 5 years
J-E2395	1 pair per 5 years
J-E2396	1 pair per 5 years
J-E2611	1 per year
J-E2612	1 per year
J-E2613	1 per year
J-E2614	1 per year
J-E2615	1 per year
J-E2616	1 per year
J-E2617	1 per year
J-E2618	1 per 5 years
J-E2619	1 per year
J-E2620	1 per year
J-E2621	1 per year
L-E1020	1 per 5 years
L-E2207	1 per month
L-E2208	1 per month
L-E2209	1 per month

Procedure Code	Maximum Limit
Wheelchair/ Pressure/ Positioning Cushions	
J-E0190	1 per 5 years
J-E2601	1 per year
J-E2602	1 per year
J-E2603	1 per year
J-E2604	1 per year
J-E2605	1 per year
J-E2606	1 per year
J-E2607	1 per year
J-E2608	1 per year
J-E2609	1 per year
J-E2611	1 per year
J-E2612	1 per year
J-E2613	1 per year
J-E2614	1 per year
J-E2615	1 per year
J-E2616	1 per year
J-E2617	1 per year
J-E2618	1 per 5 years
J-E2619	1 per year
J-E2620	1 per year
J-E2621	1 per year
J-K0734	1 per year
J-K0735	1 per year
J-K0736	1 per year
J-K0737	1 per year
Batteries	
J-E2361	2 per year
J-E2363	2 per year
J-E2366	1 per 5 years
J-E2371	1 pair per 5 years
J-K0733	2 per year
Safety Equipment	
J-E0700	1 per year
J-E0705	1 per 5 years
J-E0942	1 per year
J-E0944	1 per year
J-E0945	1 per year
J-E0960	As needed
J-E0971	1 pair per year
J-E0974	1 per year
J-E0978	1 per year
J-E0980	1 per year
Lifts	
J-E0630	1 per 5 years
J-E0635	1 per 5 years
L-E0630	1 per month
L-E0635	1 per month
Miscellaneous	
9-A9900	As Needed
9-E1340	As Needed
J-E1399	As Needed
J-K0108	As Needed

24.5.27 Respiratory Equipment and Supplies

Respiratory equipment is defined as any device that assists a client's ventilation. Respiratory equipment and supplies may be provided in the home under Home Health Services.

The following respiratory equipment requires prior authorization:

- Intermittent positive pressure breathing device.
- Electrical percussor.
- Intrapulmonary percussive ventilation (IPV).
- High-frequency chest wall compression system (HFCWCS).
- Cough-stimulating device.
- Continuous positive airway pressure (CPAP) system.
- Bi-level positive airway pressure system without backup (such as BPAP S).
- Bi-level positive airway pressure system with backup (such as BiPAP ST).
- All home mechanical ventilation equipment.
- Home oxygen systems.
- Oral device/ appliance.

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

Respiratory equipment is anticipated to last a minimum of 5 years.

For replacement of equipment due to loss by theft or fire, a copy of the police or fire report must be submitted with the measures to be taken to prevent reoccurrence.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management unit will be made by the Home Health Services unit for clients under the age of 21 years. Providers will be notified that the State will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

The durable medical equipment (DME) provider/supplier must have the appropriate license and/or certification from DSHS regarding supplying of medical devices and oxygen.

Note: *Respiratory equipment and related supplies that are not considered a benefit under Home Health Services may be considered for reimbursement through THSteps-CCP for clients younger than 21 years of age, who are THSteps-CCP eligible (e.g., clients residing in residential treatment centers).*

24.5.27.1 Nebulizers

A nebulizer is a device with a compressor that delivers respiratory medications by inhalation in the form of a mist.

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

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.

Nebulizers may be reimbursed for purchase only, and that purchase is limited to one every five years.

Use procedure code J-E0570 for purchase of the nebulizer.

Diagnosis Codes				
1363	27700	27701	27702	27703
27709	4660	46611	46619	4801
486	488	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	5070	5071	5078
5533	7469	769	7707	78609
7861				

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

Procedure Codes		
9-A4617	9-A7003	9-A7004
9-A7006	9-A7007	9-A7009
9-A7011	9-A7013	9-A7015
9-A7016	9-A7018	

Ultrasonic nebulizers do not require prior authorization for the diagnoses listed below. Use procedure code J-E0575 when billing for the ultrasonic nebulizer.

The ultrasonic nebulizer will be reimbursed only for the following diagnosis codes:

Diagnosis Codes				
1363	27700	27701	27702	27703
27709				

Use procedure codes 9-A7009 or 9-A7017 when billing supplies with an ultrasonic nebulizer.

24.5.27.2 Vaporizers

The vaporizer is a machine that creates a mist, which is released into the air.

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

Use procedure code J-E0605 when billing for vaporizers.

Vaporizers do *not* require prior authorization for the diagnoses listed below. Vaporizers will be reimbursed for the following diagnoses only:

Diagnosis Codes				
462	4644	4650	4658	4659
4660	46611	46619		

24.5.27.3 Humidification Units

Humidification units for nonmechanically ventilated clients will be purchased when a purchase is determined to be more cost effective than leasing the device with supplies. Use procedure code J-E1399 when billing for humidification units for nonmechanically ventilated clients. Procedure code J-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 will 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.

24.5.27.4 Secretion Clearance Devices

Incentive Spirometer

Incentive spirometers, including electronic spirometers, are not a benefit of the Home Health Services.

Intermittent Positive-Pressure Breathing (IPPB) Devices

Intermittent positive-pressure breathing is the application of positive pressure, frequently with aerosols or humidity, to a spontaneously breathing client, as a short-term treatment. Each treatment usually does not last more than 15 or 20 minutes.

IPPB devices require prior authorization.

The IPPB machine may be reimbursed for rental only, and that rental is limited to once per month for a maximum of four months per lifetime.

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

Use procedure code L-E0500 when billing for the IPPB.

Purchase of the IPPB device (J-E0500) is not a benefit.

The IPPB device may be authorized for the following diagnoses:

Diagnosis Codes				
27700	27701	27702	27703	27709
33510	33511	33519	3591	35921
35922	35923	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 is a small handheld device that provides positive expiratory pressure (PEP) therapy for clients who have chronic obstructive pulmonary disease (COPD), chronic bronchitis, cystic fibrosis, atelectasis, or other conditions producing retained secretions.

The mucous clearance valve requires prior authorization.

The mucous clearance valve is age-restricted to 6 years of age and older.

The mucous clearance valve may be reimbursed for purchase only, and that purchase is limited to one every five years.

Use procedure code J-S8185 for the purchase of a mucous clearance valve.

The mucous clearance valve will 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.

24.5.27.5 Electrical Percussor

An electrical percussor is a device that produces vibrations when applied to the chest wall. The purpose of this device is to improve the effectiveness of chest physiotherapy.

The electrical percussor device requires prior authorization.

The electrical percussor may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. Purchase is limited to one every five years and rental is limited to once per month for a maximum of four months per lifetime.

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 authorization for an electrical percussor.

Use procedure codes J-E0480 and L-E0480 when billing for the percussor.

24.5.27.6 Chest Physiotherapy Devices

Either an IPV, cough-stimulating device, *or* the HFCWCS generator with vest will be prior authorized. These systems are *not* prior authorized simultaneously.

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

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 by a physician familiar with the client.

High-Frequency Chest Wall Compression System

A High-Frequency Chest Wall Compression System (HFCWCS) is composed of an inflatable vest and an air-pulse generator. The generator produces high-frequency pressure pulses, which rapidly inflate and deflate the vest, creating oscillation of the chest wall.

Payment of the HFCWCS is limited to the following diagnosis codes:

Diagnosis Codes				
27700	27701	27702	27703	27709
33510	33511	33519	3591	496

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

A HFCWCS is reimbursed only when it is demonstrated that other mechanical devices or chest physiotherapy by a caregiver and/ or self have been ineffective.

The HFCWCS requires prior authorization. Requests may be considered for 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 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.

Rental cost of the HFCWCS applies toward the purchase price.

A HFCWCS generator purchase and vest purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer.

Requests for a vest replacement due to growth will 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.

Use procedure code J/L-E0483 when billing for HFCWCS for either a rental or purchase.

Intrapulmonary Percussive Ventilation (IPV)

IPV offers a form of physiotherapy which is pneumatically delivered. The IPV delivers mini-bursts of gas into the lungs at a high-frequency with aerosol therapy and positive pressure. Its purpose is to mobilize secretions.

The IPV requires prior authorization.

The IPV may be reimbursed for monthly rental only and includes all accessories.

Use procedure code L-E0481 when requesting authorization for rental of the IPV.

The IPV may be reimbursed for the following cystic fibrosis diagnosis codes:

Diagnosis Codes				
27700	27701	27702	27703	27709
33510	33511	33519	3591	496

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

The IPV is reimbursed only when it is demonstrated that an electric/pneumatic percussor or chest physiotherapy by a caregiver and/or self have not been effective.

The IPV 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 any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations and/or history of school, work, and extracurricular activity absences due to diagnosis related complications.
- Any medical reasons why the client/caregiver cannot do chest physiotherapy.
- 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 information on why other treatments have not been tried, and that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.

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

Either an IPV, cough stimulating device, or the high-frequency chest wall compression generator with vest will be authorized. These systems will not be authorized simultaneously.

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.

Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices Initial or Extended form must be signed, dated, and maintained by the provider and the prescribing physician in the client's medical record.

Cough-Stimulating Device (Cofflator)

The cough-stimulating device assists clients in secretion clearance by applying positive pressure to the airway via mask, mouthpiece or tracheostomy adapter. It then cycles to negative pressure stimulating a cough response.

The cough-stimulating device requires prior authorization.

The cough-stimulating device may be reimbursed for monthly rental only and includes all supplies.

Use procedure code L-E0482 when requesting rental of a cough-stimulating device.

The cough-stimulating device may be reimbursed for those clients with chronic pulmonary disease and/or neuromuscular disorders that affect the respiratory musculature.

The cough-stimulating device 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 any IV antibiotic therapy with dosage, frequency and duration, history of recent hospitalizations, results of pulmonary function studies if applicable, and/or history of school/work/extracurricular activity absences due to diagnosis related complications.
- Medical reasons why the client/caregiver cannot do chest physiotherapy.
- 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 information on why other treatments have not been tried, and that the client has used electrical percussor therapy for a minimum of four months before the request and that this therapy has been ineffective.

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.

24.5.27.7 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 completed by the physician familiar with the client and submitted by the provider for all positive pressure system devices.

24.5.27.8 Continuous Positive Airway Pressure (CPAP) System

A CPAP system is used to provide noninvasive positive air pressure through the nose with a mask or nasal pillows to prevent the collapse of the oropharyngeal walls during sleep. It is used primarily for the treatment of obstructive sleep apnea. Other conditions may be considered based on medical necessity.

The CPAP system requires prior authorization.

The CPAP system may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. 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.

Use procedure code J/L-E0601 when requesting authorization for the rental or purchase of the CPAP system.

Clients who have a current prior authorization for a CPAP/BiPAP S may continue to rent these items until the authorization period expires. After the current authorization period expires, then the criteria in the following paragraph applies to any further authorizations of CPAP/BiPAP. Providers must supply a new CPAP/BiPAP to clients at the beginning of the new authorization period.

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

CPAP may be approved initially for three months if the duration of the symptoms is at least six months and one of the following:

- The Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) is greater than 15 per hour.
- The Sleep Study RDI or AHI is greater than 10 per hour with the lowest oxygen saturation during the study is less than 80 percent.

24.5.27.9 Pediatric CPAP Changes

One of the following oxygen saturation levels may be used for clients under 21 years of age:

- 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.

24.5.27.10 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 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.

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

A BiPAP S is used to provide noninvasive inspiratory positive airway pressure and expiratory positive airway pressure through the nose with a mask to prevent the collapse of the oropharyngeal walls during sleep. This equipment is used primarily for obstructive sleep apnea.

The BiPAP S requires prior authorization.

The BiPAP S may be reimbursed for rental or purchase depending on the physician's predicted length of treatment. 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.

The BiPAP S will not be authorized once a CPAP is purchased.

Use procedure code L/ J-E0470 when requesting authorization for the rental or purchase of the BiPAP S.

Clients who have a current prior authorization for a CPAP/ BiPAP S may continue to rent these items until the authorization period expires. After the current authorization period expires, then the criteria in the following paragraph applies to any further 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.

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, *and*
- Duration of symptoms of at least six months, and
- The Sleep Study RDI or AHI is greater than 15 per hour, *or*
- The Sleep Study RDI or AHI greater than 10 per hour with the lowest oxygen saturation during study is less than 80 percent or oxygen saturation equal to or less than 92 percent for clients under 21 years of age.

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 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.

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

A BiPAP ST is used to provide timed noninvasive inspiratory positive airway pressure and expiratory positive airway pressure through the nose with a mask when BiPAP S has been proven ineffective or through a tracheostomy.

The BiPAP ST requires prior authorization.

The rental of a BiPAP ST may be reimbursed only once per month.

Purchase of the 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.

Use either procedure code L-E0471 or L-E0472 when requesting 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*
- Oxygen saturation equal to or less than 92 percent in clients under 21 years of age.
- 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).

Continued 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 under 21 years of age. 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.

Home Mechanical Ventilation Equipment

Ventilators are used for clients who do not have adequate respiratory function. 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).

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.

24.5.27.13 Volume Ventilators

A volume ventilator may operate, using room air and/ or oxygen, in various phases, modes and variables, which are time controlled, pressure controlled, volume controlled or a combination of these. A volume ventilator may be operated in any of the following:

Ventilation Modes

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

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 volume ventilator is prior authorized for rental only for those clients who have a tracheostomy.

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.

Use procedure codes L-E0450, L-E0463, and L-E0464 when requesting prior authorization for the volume ventilator.

24.5.27.14 Negative Pressure Ventilators

A negative pressure ventilator decreases atmospheric pressure to a predetermined negative pressure immediately outside the chest or body to allow passive lung expansion from normal air pressure.

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.

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

Use procedure code L-E0460 when requesting prior authorization for a negative pressure ventilator.

One of the following devices may be authorized with a portable negative pressure ventilator using procedure codes J/ L-E0457 and J/ L-E0459. These devices may be reimbursed for an initial three-month rental period.

The listed application devices may be purchased following the initial three-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 one every five years. Reimbursement for rental is limited to once per month for a total of four months.

24.5.27.15 Ventilator Service Agreement

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.

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.

A ventilator service agreement may be reimbursed only once per month.

Use procedure code 9-A9900 when requesting the ventilator service agreement.

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.

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, tracheostomy filters, and 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. The provider must maintain documentation on monthly visits.
- Provide a substitute ventilator while the manufacturer's recommended preventive maintenance is being performed on the client-owned ventilator.

Requests for a continued six-month 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.

24.5.27.16 Oxygen Therapy

Oxygen therapy is defined as supplemental oxygen administration for the purpose of relieving hypoxemia and preventing damage to the tissue cells as a result of oxygen deprivation.

All oxygen therapy and related equipment requires prior authorization.

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

Multiple oxygen delivery systems (e.g., liquid or gas) will not be authorized concurrently.

Moisture exchangers for use with non-mechanically ventilated clients may be considered for reimbursement when billed with procedure code 9-A9900.

Rental of oxygen equipment includes all supplies and refills.

Supplies and refills may be prior authorized for those clients that own their own oxygen systems.

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.
- 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.

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 by the physician familiar with the client and submitted by the provider.*

24.5.27.17 Initial Oxygen Therapy Medical Necessity Certification

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 under 21 years of age 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 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 the following clinical indications:

- Neurological evaluation with diagnosis, *and*
- Documented failed medication therapy.

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

24.5.27.18 Oxygen Therapy Recertification

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.*

24.5.27.19 Oxygen Therapy Home Delivery System Types

The oxygen concentrator systems are the preferred (standard) delivery system of in-home oxygen therapy. This type of system concentrates oxygen molecules from the ambient air, generating concentrations of up to 90 to 98 percent.

Use procedure code L-E1390 for the rental of an oxygen concentrator system.

The reimbursement payment for the rental of the procedure code L-E1390 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) (L-E0424).
- Liquid oxygen reservoir systems (L-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 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.
- Use procedure codes L-E0431, L-E0434, and L-K0738 when billing for the portable oxygen systems. When procedure code L-K0738 is billed for the same dates of service as procedure code L-E0431, procedure code L-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.

24.5.27.20 Tracheostomy Tubes

A tracheostomy tube fits into a tracheal stoma and is used for those clients who have undergone surgical tracheostomy. The procedure codes and modifiers noted in the following tables may be used when requesting prior authorization for a tracheostomy tube. Prior authorization requests must provide sufficient information to support the determination of medical necessity for the requested item.

A tracheostomy tube may be reimbursed for purchase only and is limited to one per month. Authorization for a tracheostomy tube will be considered with procedure code 9-A7520, 9-A7521, or 9-A7522. Add modifier TF when billing a tracheostomy with specialized functions. Add modifier TG when billing a custom made tracheostomy. The manufacturer's retail pricing information and a physician statement addressing the reason the client cannot use a standard tracheostomy tube are required when requesting prior authorization.

Use procedure code 9-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 (9-A7520-TG or 9-A7521-TG) is requested.

24.5.27.21 Pulse Oximetry

Pulse oximeters are not a benefit of Home Health Services.

Authorization for reimbursement of sensor probes (reusable or disposable) may be considered only for those with a client owned pulse oximeter (e.g., purchased through another source).

Use procedure code 9-A4606 for reimbursement of sensor probes (reusable or disposable).

24.5.27.22 Procedure Codes and Limitations for Respiratory Equipment and Supplies

Procedure Code	Limitations
Nebulizers	
9-A4617	2 per month
9-A7003	2 per month
9-A7004	2 per month

Procedure Code	Limitations
9-A7006	2 per month
9-A7007	2 per month
9-A7011	Every 6 months
9-A7013	1 per month
9-A7015	2 per month
9-A7016	2 per month
9-A7018	4 per month
9-S8101	2 per month
J-E0570	Every 5 years
Ultrasonic Nebulizers	
9-A7009	Every 2 years
9-A7014	1 per year
J-E0575	Every 5 years
Vaporizers	
J-E0605	Every 5 years
Intermittent Positive-Pressure Breathing (IPPB) Device	
L-E0500	4 months per life
Mucous Clearance Valve (i.e., Flutter)	
J-S8185	Every 5 years
Chest Physiotherapy Devices	
9-A7025	Every 5 years
9-A7026	2 per year
J-E0480	Every 5 years
J-E0483	1 per lifetime
L-E0480	1 per month
L-E0481	1 per month
L-E0482	1 per month
L-E0483	1 per month
CPAP/ BiPAP	
9-A7034	Every 3 months
9-A7035	Every 6 months
9-A7037	1 per month
9-A7038	Every 6 months
J-E0470	1 per 5 years
J-E0471	1 per 5 years
J-E0561	1 per 5 years
J-E0562	1 per 5 years
J-E0601	Every 5 years
J-K0553	1 per 3 months
J-K0554	2 per month
J-K0555	2 per month
L-E0470	1 per month
L-E0471	1 per month
L-E0561	1 per month
L-E0562	1 per month
L-E0601	1 per month
Home Mechanical Ventilator Equipment	
9-A4481	31 per month
9-A4483	31 per month
9-A4611	Every 5 years
9-A4612	Every 5 years
9-A4613	Every 5 years
9-A4614	2 per year
9-A4623	1 per month
9-A4629	31 per month
9-A7520	1 per month
9-A7520-TF	1 per month
9-A7520-TG	1 per month
9-A7521	1 per month
9-A7521-TF	1 per month
9-A7521-TG	1 per month
9-A7522	1 per month
9-A7522-TF	1 per month
9-A7522-TG	1 per month
9-A7525	4 per month
9-A7526	8 per month
9-L8501	2 per year
J-E0457	Every 5 years
J-E0459	1 per lifetime
J-S8189	Limited per policy
L-E0450	1 per month
L-E0457	1 per month
L-E0459	1 per month
L-E0460	1 per month
L-E0463	1 per month
L-E0464	1 per month
L-E0580	1 per month
Ventilator Maintenance Agreement	
9-A9900	1 per month
Oxygen Therapy	
9-A4615	Every 2 weeks
9-A4616	Every 3 months
9-A4618	4 per month
J-E0565	Every 5 years
J-E1353	1 per year
L-E0424	1 per month
L-E0431	1 per month
L-E0434	1 per month

Procedure Code	Limitations
L-E0439	1 per month
L-E0441	1 per month
L-E0442	1 per month
L-E0443	1 per month
L-E0444	1 per month
L-E0565	1 per month
L-E1390	1 per month
L-K0738	1 per month
Suction Pumps	
9-A4605	10 per month
9-A4624	90 per month
9-A4628	2 per month
9-A7000	4 per month
9-A7002	8 per month
J-E0600	Every 5 years
Miscellaneous	
9-A4606	4 per month
9-A4627	Every 6 months
J-S8999	1 per year
L-E1399	Limited by policy

When procedure code L-K0738 is billed with procedure code L-E0431, procedure code L-E0431 will be denied.

24.5.28 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.

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

Procedure Codes		
Nebulizer Supplies/ Equipment*		
9-A4614	9-A4627	9-S8101
J-E0570	J-E0575	L-E0580
Incontinence Supplies ***		
9-A4310	9-A4311	9-A4312
9-A4313	9-A4314	9-A4315
9-A4316	9-A4320	9-A4321
9-A4322	9-A4326	9-A4327
9-A4328	9-A4330	9-A4335
9-A4338	9-A4340	9-A4344
9-A4346	9-A4351	9-A4352
9-A4353	9-A4354	9-A4355
9-A4356	9-A4357	9-A4358
9-A4402	9-A4554	9-A5102
9-A5105	9-A5112	9-A5113
9-A5114	9-A5120	9-A5121
9-A5122	9-A5131	

*** Prior authorization is required for certain diagnoses and if limitations are exceeded. Refer to "Nebulizers" on page 24-58**
**** Prior authorization is required for some procedure codes if the maximum limitation is exceeded. Refer to "Incontinence Supplies and Equipment" on page 24-21**

24.5.29 Nutritional (Enteral) Products, Supplies, and Equipment

24.5.29.1 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.

Enteral products, including nutritional formulas, food thickener, and related supplies and equipment, are a benefit under Home Health Services for clients 21 years of age and older who require tube feeding as their sole source of nutrition. Prior authorization is required for all enteral products, supplies, related DME, 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. Enteral products for clients who can take nutrition by mouth and/ or that are used as a supplement will not be prior authorized.

Nutritional products and supplies will not be reimbursed for clients receiving TPN. Any nutritional products and/ or supplies are included as part of the reimbursement for TPN. Requests are reviewed for reasonable amounts.

Enteral products for clients who can take nutrition by mouth and/or that are used as a supplement will not be prior authorized.

To avoid unnecessary denials, the physician must provide correct and complete, signed, and dated information, including documentation of the medical necessity of the equipment and/or supplies requested. The physician must maintain documentation of medical necessity in the clients medical record. The requesting provider may be asked for additional information to clarify or complete a request for the nutritional products, supplies, or equipment.

To be reimbursed as a home health benefit:

- The client must be eligible for home health benefits.
- The criteria listed in this policy for the requested supplies/equipment must be met.
- The supplies/equipment requested must be medically necessary.
- Federal financial participation must be available.
- The client's nutritional status would be compromised without the requested enteral nutritional products/supplies/equipment.

Note: *For clients under 21 years of age who do not meet criteria through Home Health Services, products, supplies, and equipment may be considered through CCP.*

The completed, signed, and dated DME Certification and Receipt Form is required before reimbursement can be made for any DME delivered to a client. The certification form must include the name of the item, the date the client received the DME/products/supplies, and the signatures of the provider and the client or primary caregiver. This form must be maintained by the DME provider in the client's medical record.

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 are the client's sole source of nutrition.
- Total caloric intake prescribed by the physician.
- Acknowledgement that the client has a gastrostomy or nasogastric tube.
- Necessary product information.

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

Prior authorization may be given for up to twelve 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.

24.5.29.2 Enteral Nutritional Products

All enteral nutritional products paid under the Texas Medicaid Program are paid based on units of 100 calories (as documented by the manufacturer) with the appropriate "B" code (as documented by the Statistical Analysis DME Regional Carrier [SADMERC] 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).

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. Payment is based on the lower of billed charges or the Medicaid allowed fee, with the Medicaid allowed fee based on the appropriate "B" code, modifier, and units of 100 calories.

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.

The Palmetto GBA SADMERC Product Classification List is located on its website (www.palmettogba.com).

Procedure Codes		
9-B4100 No modifier required	9-B4150 with modifiers U2, U3, U4, U5	9-B4152 with modifiers U2, U3, U6
9-B4153 with modifiers U5, U6, U7, U8, U9	9-B4154 with modifiers U1, U2, U3, U4, U5, U6, U7, U8, U9, UA, UB, UC, UD	9-B4155 with modifiers U2, U3, U4, U5, U8, UC
9-B4157 No modifier required		

Modifier	Fee Per Unit
U1	$0.30
U2	$0.50
U3	$0.70
U4	$0.85
U5	$1.05
U6	$1.70
U7	$2.00
U8	$2.50
U9	$3.00
UA	$4.00

Modifier	Fee Per Unit
UB	$5.00
UC	$6.00
UD	Manually priced

24.5.29.3 Enteral Feeding Pumps

Enteral feeding pumps with alarms are a benefit of Home Health Services for those clients who require enteral feeding. Enteral feeding pumps with alarms require prior authorization.

The Home Health Services (Title XIX) Durable Medical Equipment (DME)/ Medical Supplies Physician Order Form requesting enteral feeding pumps and supplies must be completed, signed, and dated by a physician familiar with the client before requesting prior authorization.

Sole source enteral equipment is a benefit of Home Health Services for clients regardless of age. When enteral nutrition is not the client's sole source of nutrition, enteral equipment is only a benefit for clients under 21 years of age.

Enteral feeding pumps may be leased or purchased with documentation that gravity or syringe feedings have caused complications or are otherwise not indicated. Complications may include, but are not limited to, the following:

- Reflux and/ or aspiration.
- Severe diarrhea.
- Dumping syndrome.
- Administration rate of less than 100 ml/ hr.
- Blood glucose fluctuations.
- Circulatory overload.
- Gastrostomy/ jejunostomy tube used for feeding.

Enteral feeding pumps that have been purchased are anticipated to last a minimum of 5 years and may be considered for replacement when 5 years have passed and/ or the equipment is no longer repairable. The DME may then be considered for prior authorization. Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence, must be submitted.

In situations where the equipment has been abused or neglected by the client, the client's family, or the caregiver, a referral to the DSHS THSteps Case Management Department will be made by the Home Health Services Prior Authorization Department for clients under 21 years of age. Providers will be notified that the state will be monitoring the client's services to evaluate the safety of the environment for both the client and equipment.

Enteral Supplies

Enteral supplies require prior authorization. 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-Bolus, pump, and/ or gravity.

Syringes without needles are considered reusable for enteral administration of medication. These syringes are limited to eight per month.

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

Feeding supply kits are limited to one per day. Gravity bags and pump nutritional containers are included in the feeding supply kits and will not be reimbursed separately.

Sole source enteral feeding supplies are a benefit of Home Health Services for clients regardless of age. When enteral nutrition is not the client's sole source of nutrition, enteral feeding supplies are only a benefit for clients under 21 years of age.

A food scale is payable for clients on specific diets with foods measured in grams (e.g., ketogenic diets). This service requires prior authorization and has a maximum allowable fee of $60.

Medical nutritional products for clients 20 years of age and younger remain a benefit of THSteps-CCP.

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

The TMHP Home Health Services Prior Authorization Department will not issue authorization of enteral products/ supplies/ equipment if the client is receiving TPN/ hyperalimentation. TPN/ Hyperalimentation is reimbursed as a daily global fee to cover visits by an RN for teaching and monitoring the client, customary and routine laboratory work, and enteral supplies and equipment.

Refer to: "In-Home Total Parenteral (TPN)/ Hyperalimentation Supplier" on page 27-1.

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 will be limited to two per year. Additional tubes may be reimbursed if documentation submitted indicates medical necessity, such as infection at gastrostomy site, leakage or occlusion. Obturated gastrostomy tube replacements are performed in the physicians office or outpatient setting and are not a benefit of Home Health Services.

24.5.30 Limitations, Exclusions

Payment cannot be made for any service, supply or equipment for which FFP is not available.

For clients who are younger then 21 years of age and who are eligible to receive THSteps services, refer to "THSteps-Comprehensive Care Program (CCP)" on page 43-33 to find which of these items are a benefit for THSteps-CCP.

Home Health Services does not cover the following:

- Adaptive strollers, travel seats, push chairs, car seats.
- Administration of non-FDA-approved medications/treatments or the supplies and equipment used for administration.
- Aids for daily living, such as toothpaste, spoons, forks, knives, and reachers.
- Allergy injections.
- 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 (for example, 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.
- Developmental therapy.
- Diapers and wipes for clients younger than 4 years of age.
- Drugs or biologicals (except as specifically provided for in this manual).
- 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.
- Homemaker services. Clients requiring this type of care should contact their local DSHS office for information about community-based programs for PHC, day activities, or other related services.
- Home whirlpool baths, spas, home exercisers/gym equipment, hemodialysis equipment, safety wall rails, toys/therapy equipment.
- Inpatient rehabilitation.
- Medical social services.
- Mental health psychiatric services.
- Nursing visits to administer long-term SQ/SC, IM, oral, or topical medications, such as insulin, vitamin B_{12}, or deferoxamine, or to set up medications such as prefill insulin syringes or medication boxes, on a long-term basis.
- Nutritional counseling.
- Orthotics, braces, prosthetics including but not limited to voice prosthetic, and artificial larynx.
- Parapodiums.
- Pneumocardiograms.
- PDN services.
- Respite care (caregiver relief).
- Seat lift mechanisms and seat lift chairs.
- Services payable by any health, accident, other insurance coverage, or by a private or other governmental benefit system or legally liable third party resource.
- Shipping, freight, delivery travel time.
- SN visits when:
  - The medication is not considered medically necessary to the treatment of the individual's illness or is not FDA-approved.
  - The administration of medication exceeds therapeutic frequency or duration by accepted standards of medical practice.
  - A medical reason does not prohibit the administration of the medication by mouth.
  - The client, a primary caregiver, a family member, and/or neighbor has previously been taught to administer SQ/SC, IM and IV injections medications and has demonstrated competency.
  - The purpose of the visit is to administer chemotherapeutic agents or blood products.
- Speech therapy.
- Structural changes to homes, domiciles, or other living arrangements.
- Vehicle mechanical and/or structural modifications, such as wheelchair lifts.
- Visits made primarily for performing housekeeping services are not considered a benefit of the Home Health Services Program. These requests should be referred to in-home and family support service at HHSC.

Refer to: "Texas Medicaid Program Limitations and Exclusions" on page 1-19.

24.6 Medicaid Relationship to Medicare

24.6.1 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 younger than 65 of age years without Medicare Part A or B:
  - If the agency erroneously submits a SOC notice to Medicare and does not contact TMHP for 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 older than 65 years of age 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 denial letter from Medicare.
  - If the agency receives a Medicare denial letter and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days from the date on the denial letter from Medicare, 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 Medicare Remittance Notice and final review decision letter before considering the request for authorization.

24.6.2 Benefits for Medicare/ Medicaid Clients

For eligible Medicare/ Medicaid clients, Medicare is the primary coinsurance and providers must contact Medicare first for authorization and reimbursement. Medicaid pays the Medicare deductible on Part B claims for qualified home health clients. Home health service 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 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 authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: "Third Party Resources (TPR)" on page 4-14.

24.6.3 Medicare/ Medicaid Authorization

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

Note: *For MQMB clients, do not submit authorization requests to TMHP if the Medicare denial reason states "not medically necessary." Medicaid only will consider authorization requests if the Medicare denial states "not a benefit" of Medicare.*

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. The Texas Medicaid Program 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.

24.6.4 Medicare/ Medicaid Authorization and Reimbursement

To ensure Medicare benefits are used first in accordance with Texas Medicaid Program regulations, the following procedures apply when requesting Medicaid authorization and payment of home health services for clients.

Contact TMHP for authorization of Medicaid services (based on medical necessity and benefits of Home Health Services) within 30 days of the date on the Medicare final denial letter. Fax a copy of the original Medicare final denial letter and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.

A Medicare denial letter is not required when a client is eligible for Medicare/ Medicaid and needs HHA visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial HHA visit and at least every 60 days (on the same day a HHA visit is made) thereafter as long as no skilled need exists. A SN supervisory visit is reimbursable, but an SN visit made for the primary purpose of assessing a client's nursing care is not.

The SOC date will be the date of the first requested Medicare home health services visit as listed on the original Medicare denial letter.

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 older than 65 years of age 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: "Home Health Skilled Nursing Services" on page 24-9.

24.7 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 five 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 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" on page xi.

24.8 Claims Information

Use only type of business (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 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 claim form. Providers may purchase UB-04 CMS-1450 and CMS-1500 claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS 1450 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: Section 3, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

"Claims Filing" on page 5-1 for general information about claims filing.

"UB-04 CMS-1450 Claim Filing Instructions" on page 5-30.

"CMS-1500 Claim Filing Instructions" on page 5-22 for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

The prior authorization number must appear on the UB-04 CMS-1450 claim in Block 63 and in Block 23 of the CMS-1500. 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.

24.9 Claim Filing Resources

Refer to the following sections and/or forms when filing claims:

Resource	Page Number
Automated Inquiry System (AIS)	xiii
TMHP Electronic Data Interchange (EDI)	3-1
CMS-1500 Claim Filing Instructions	5-22
UB-04 CMS-1450 Claim Filing Instructions	5-30
TMHP Electronic Claims Submission	5-13
Communication Guide	A-1
DME Certification and Receipt Form	B-35
External Insulin Pump	B-39
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS]; Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]-Initial Request)	B-52
Medicaid Certificate of Medical Necessity for Chest Physiotherapy Devices (High-Frequency Chest Wall Compression System [HFCWCS); Intrapulmonary Percussive Ventilation Device [IPV]; Cough-Stimulating Device [Cofflator]-Extended Request)	B-53
Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form Instructions (2 Pages)	B-42
Home Health Services (Title XIX) Durable Medical Equipment (DME)/Medical Supplies Physician Order Form	B-44
Home Health Services Plan of Care (POC)	B-46
Home Health Services Plan of Care (POC) Instructions	B-47
Home Health Services Prior Authorization Checklist	B-48
Wheelchair Seating Evaluation Form (THSteps-CCP/Home Health Services) (next six pages)	B-117
Home Health Services DME/Medical Supplies Claim Example	D-16
Home Health Services SN Visit Claim Example	D-16
Home Health Services SN Visit and Physical Therapy Claim Example	D-17
Acronym Dictionary	F-1