

## Equipment and Supplies

Revised: September 13, 2023

- Eligible Providers
  - TPL and Medicare
- Eligible Members
- Covered Services
  - Airway Clearance Devices
  - Allergen-Reducing Products for Children
  - Ambulatory Assist Equipment
  - Apnea Monitors
  - Augmentative Communication Devices
  - Bath and Toilet Equipment
  - Breast Pumps
  - Bone Growth Stimulators
  - Diabetic Equipment and Supplies
  - Electrical Stimulation Devices
  - External Defibrillators
  - Gloves
  - Hearing Aids
  - Hospital Beds
  - Humanitarian Use Devices
  - Incontinence Products
  - Lower Limb Prosthetics
  - Miscellaneous Codes
  - Miscellaneous Products
  - Mobility Devices
  - Nebulizers
  - Non-Mobility Equipment Repairs
  - Nutritional Products
  - Orthopedic and Therapeutic Footwear
  - Orthotics
  - Oximeters
  - Oxygen Equipment
  - Patient Lifts and Seat Lift Mechanisms
  - Pneumatic Compression Devices
  - Positioning Equipment
  - Positive Airway Pressure for Treatment of Obstructive Sleep Apnea
  - Pressure Reducing Support Surfaces
  - Prosthetics and Orthotics
  - Respiratory Equipment
  - SAD Lights
  - Specialized Wound Treatment Technology
  - Spirometers
  - Standers
  - Topical Products Defined as Drugs
  - Transcutaneous Electrical Nerve Stimulator (TENS)
  - Transfer and Mobility Device (TRAM)
  - Ultraviolet Light Therapy Systems

- [Urological and Bowel Supplies](#)
- [Noncovered Services](#)
- [Billing and Documentation](#)
  - [Provider Initiated Upgrades](#)
  - [Authorization Requirements](#)
  - [Documentation](#)
  - [Hospitalized Recipients](#)
  - [Dispensing of Equipment and Supplies](#)
  - [Face-to-Face Rule for Durable Medical Equipment, Appliances and Supplies](#)
- [Billing](#)
- [Legal References](#)
- 

### **Eligible Providers**

To be eligible to [enroll](#) as a [medical supplier](#), providers must purchase medical equipment or supplies for sale or rental to the general public. Providers must be able to perform or arrange necessary repairs and maintenance to equipment offered for sale or rental. Providers must also meet all requirements set forth in [Minnesota Statutes 256B.0625, subdivision 31](#).

Some kinds of equipment or supplies have special provider requirements. Those requirements are found on the coverage policy page for the specific item.

The following are eligible to provide most medical equipment and supplies:

- Federally qualified health centers
- Home health agencies
- Indian Health Services
- Medical suppliers (including oxygen contract vendors)
- Pharmacies
- Rural health clinics

The following are eligible providers for medical equipment and supplies only when the medical equipment and supplies are provided as a necessary supplement to the direct treatment of a member's condition (for example: crutches and splints).

- Clinics
- Clinical nurse specialists
- Hospital outpatient facilities
- Nurse practitioners
- Physician assistants
- Physicians
- Podiatrists

### **Third Party Liability (TPL) and Medicare**

Providers must meet any provider criteria, including accreditation and surety bond requirements, for third-party insurance or for Medicare to assist members for whom Minnesota Health Care Programs (MHCP) is not the primary payer.

- Providers who cannot receive Medicare payment for the service must refer and document the referral of dual-eligible members to Medicare providers when Medicare is determined to be the appropriate payer.
- Providers who cannot receive TPL payment for the service must refer members to TPL providers.

- Providers who do not meet provider requirements for the primary payer will not be reimbursed by MHCP.

### **Eligible Members**

MHCP members are eligible for coverage. Review the [Benefits at a Glance](#) for more information.

Covered waiver items are not subject to this policy. Please refer to the [Billing for Waiver and Alternative Care Program](#) section of the [MHCP Provider Manual](#) for more information.

### **Covered Services**

MHCP covers medical supplies and equipment, subject to limitations, authorization, and other requirements.

- When the medical equipment or supply is purchased for a member, the item is the member's property.
- All purchased equipment must be new upon delivery to the member.
- Rent for most durable medical equipment is covered to the purchase price of the equipment. When the purchase price is reached, the item is the member's property. Equipment that is intended to rent until converted to purchase must be new equipment. Used equipment may be used for short-term rental, but if eventually converted to purchase, must be replaced with new equipment.
- MHCP assumes a reasonable useful lifetime of five years for all durable medical equipment. Members cannot automatically obtain a new piece of equipment after five years if the first piece is still in working order. Likewise, if repairs are requested for a piece of equipment that is more than five years old, the integrity of the equipment and ability to last another five years will be assessed and the least costly alternative recommended (replacement versus repair).
- MHCP will not cover equipment that serves the same purpose as usable equipment previously purchased for the member.
- MHCP covers repairs to medically necessary member-owned equipment and maintenance on equipment that requires frequent cleaning or routine calibration to ensure proper working order.
- Covered devices that are subject to FDA approval must be dispensed according to its approval guidelines.

To determine the appropriate HCPCS code to use for an item, refer to the Medicare Pricing, Data Analysis and Coding (PDAC) Palmetto GBA [Durable Medical Equipment Coding System](#) webpage.

Refer to the [Medical Supply coverage guide \(PDF\)](#) for information about coverage and limits for supplies and equipment not included in this manual.

### **Living Arrangement Codes**

Refer to the [Medical Supply coverage guide \(PDF\)](#) for services that may be affected by living arrangement.

- 41:** NFI (Nursing Facility I) Medicare certified
- 42:** NFII (Nursing Facility II) Non-Medicare certified
- 43:** Intermediate Care Facility Developmental Disabilities (ICF DD)
- 44:** Short Term Stay NFI
- 45:** Short Term Stay NFII
- 46:** Short Term Stay ICF DD
- 48:** Medical Hospital > 29 days
- 55:** Rule 203 Adult Foster Home
- 80:** Community

## **Per Diem Coverage**

### **Skilled Nursing Facility**

Nearly all durable medical equipment and supplies are covered in the per diem for long-term care, with the exclusion of customized wheelchairs for members who cannot use a standard wheelchair. Refer to the [Medical Supply coverage guide \(PDF\)](#) for details on specific HCPCS codes (the "Included in LTC per diem?" column lists whether or not something is covered in a skilled nursing facility).

### **Intermediate Care Facilities for individuals with developmental disabilities (ICF/DD)**

Includes most durable medical equipment and supplies within its per diem. Wheelchair rentals and purchases are not included in the per diem. Refer to the [Medical Supply coverage guide \(PDF\)](#) for details on specific HCPCS codes (the "Included in LTC per diem?" column lists whether or not something is covered in an intermediate care facility).

### **Hospice**

All durable medical equipment and supplies related to a hospice diagnosis are covered by the hospice benefit. If a member requires durable medical equipment and supplies for an unrelated diagnosis it will be paid by MHCP separately. Refer to the [Hospice Services](#) section of the MHCP Provider Manual for more details.

### **21<sup>st</sup> Century Cures Act**

Durable medical equipment payments will be subject to a Medicare upper payment limit according to the 21st Century Cures Act beginning with dates of service on and after Jan. 1, 2018. Based on the upper payment limit calculation in the first half of 2019, payment in excess of the total Medicare limit may be subject to payment recovery. Refer to the [Limit on Federal Financial Participation for Durable Medical Equipment in Medicaid](#) webpage on the Centers for Medicare & Medicaid Services website for more information.

### **Correct Coding Initiative**

MHCP has implemented National Correct Coding Initiative (NCCI) edits. Two types of NCCI edits exist and apply to durable medical equipment, medical supplies, prosthetics and orthotics:

- 1) Procedure code to procedure code (PTP) edits that define pairs of HCPCS/CPT codes that should not be reported together
- 2) Medically Unlikely Edits (MUEs) or units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units is unlikely to be correct

How to correctly follow NCCI edits when billing:

- Bill a date span when there is an NCCI edit on a code you are billing a month's worth of supplies for. The first date in the date span should be the date the supplies are dispensed. The number of supplies distributed in the date span should not exceed the daily limit for any day within that date span unless an NCCI exception is allowed and the correct modifiers are used.
- You must follow our monthly and annual limits when applicable regardless of the MUE. Authorization is required for quantities exceeding our policy limits.
- An NCCI modifier may be used to bypass an NCCI edit only when appropriate according to NCCI policy
- Authorization requests must contain the NCCI modifier when applicable and must match exactly what is billed
- Review the [Minnesota National Correct Coding Initiative \(NCCI\)](#) webpage for additional information.
- Review Medicaid's [Medicaid NCCI Edit Files](#) webpage to look up PTP and MUE edits

## Miscellaneous Codes

Use the most specific HCPCS code for the item being dispensed. Do not use miscellaneous codes for the sole purpose of trying to receive higher reimbursement.

### MHCP-acceptable miscellaneous HCPCS codes (when no other appropriate code is available)

Procedure Code	Description	Usage	Prior Authorization Requirements
A4335	Incontinence supply; miscellaneous	Use for supplies relating to urinary or fecal incontinence	None
A4421	Ostomy supply; miscellaneous	Use for any miscellaneous supplies for ostomies in the colon, ileum, abdomen, or similar	None
A4649	Surgical supply; miscellaneous	Use for miscellaneous wound care and surgical supplies	Over \$400 and specific items listed in each chapter
A9999	Miscellaneous DME supply or accessory; not otherwise specified	Used for parts or accessories needed for durable medical equipment (that is, replacement of batteries or filter)	Over \$400
B9998	Enteral supplies; not otherwise classified	Use for supplies relating to enteral nutrition	None
B9999	Parenteral supplies; not otherwise classified	Use for supplies relating to parenteral nutrition	None
E1399	Durable medical equipment (DME); miscellaneous	Use for durable medical equipment	Over \$400 and specific items listed in each chapter
S8189	Tracheostomy supply; not otherwise classified	Use for miscellaneous tracheostomy supplies only	None
T5999	Supply; not otherwise specified	Use for supplies that do not fit other more specific miscellaneous supply codes	None

## Billing Miscellaneous Codes

When billing the same HCPCS code for multiple products, use modifier 76 for each additional line.

If billing multiple units of the same product, bill using the correct miscellaneous code modifier and indicate the number of units dispensed.

Miscellaneous codes that do not require authorization must have a description in the notes field on the Services tab in MN-ITS.

## Miscellaneous Products

### Sharps Disposal Containers

Members who self-administer medications using syringes may receive sharps disposal containers. Bill using A4211 and modifier U3 along with appropriate pricing information as outlined in the [Billing Policy](#) section. Submit a pricing attachment for all claims. When billing for members with Medicare, include an attachment that clearly states "sharps container not covered by Medicare" or add this statement under claim information in the claim note field in MN-ITS.

## **Weighted Blankets or Vests**

**Code:** E1399 NU

Weighted blankets or vests are covered for members who have developmental disabilities, including autism spectrum disorders. The function of the weighted blankets is to provide proprioception (deep pressure), which has a calming effect that allows people with developmental disabilities to interact with their environment. Documentation needs to include relevant diagnoses of the member and evaluation performed by an occupational therapist that justifies medical necessity. Authorization is required for submitted charge over \$400.

## **Topical Products Defined as Drugs**

Skin care products classified as drugs may be covered under the following circumstances:

- The item must be produced by a manufacturer that has a rebate agreement with CMS.
- The [pharmacy](#) provider must submit the claim electronically using the 11-digit [National Drug Codes](#) (NDC). State law does **not** allow medical equipment and supply providers or home health care agencies to provide items that meet the definition of a drug.

The following items are defined as drugs and may be covered only as described in the two bullet points under Topical Products defined as Drugs:

- Aluminum acetate solution and lime sulfur dressing and soaks
- Aluminum chloride, fluorouracil and hydroquinone solutions
- Anti-acne medications
- Antibiotic-steroid combinations
- Antifungal compounds
- Anti-psoriasis and anti-eczema medications
- Antiseptics
- Burn anti-infective agents
- Enzymes
- Lactic acid lotion
- Scabicides and pediculicides
- Sterile saline or water (includes irrigation solutions labeled as Rx legend)
- Topical anesthetic and antipruritic solutions
- Topical anti-infective agents and cleaners
- Topical corticosteroid
- Urea solutions
- Vitamin A & D ointments
- Wart medications
- Zinc oxide compounds

This is not an inclusive list. Not all products that fit into one of the following categories are covered. Pharmacies should use the NDC Search site [Minnesota Medicaid Fee-For-Service Pharmacy Program](#) or [National Drug Code Search](#) to determine MHCP coverage of individual drug products.

**Topical products (not defined as drugs):** Lubricants for ostomy members, non-legend sterile saline irrigation solutions, skin barriers and other topical products that do not contain active ingredients and are not classified as drugs may be billed with the appropriate HCPCS code. These items require a written order from the physician that includes the exact description of the product to be dispensed, the amount needed and the length of time needed.

## **Typically Noncovered Services**

The following categories of equipment and supplies are never covered by MHCP:

1. Items of convenience
2. Items that are useful for individuals who don't have an illness or injury
3. Environmental or home modifications
4. Lack of scientific evidence
5. Not the standard of treatment for an illness or injury

The following list of items are not typically covered because they meet one of the criteria under Typically Noncovered Services:

- Air conditioners
- Bathroom scales
- Bathtub wall rails
- Beds - oscillating and lounge beds, bed baths and lifters, bed boards, tables and other bed accessories
- Blood glucose analyzer - reflectance colorimeter
- Car seats, standard use
- Cervical roll or pillow
- Clothing
- Control units and battery device adapters
- Dehumidifiers - room or central
- Diathermy machines
- Disposable wipes - including Attends wash cloths
- Disposable ice packs and disposable heat wraps
- Elevators and stair lifts that are affixed to the home
- Enuresis or bed-wetting alarms
- Environmental products (for example, air filters, purifiers, conditioners, hypoallergenic bedding and linens)
- Exercise equipment
- Food blenders
- Grab bars that are affixed to the home
- Heat and massage foam cushion pads
- Home security systems
- Household equipment and supplies such as ramps, switches, tableware and feeding instruments
- Humidifiers - room type or central
- Hygiene supplies and equipment, including hand-held shower units and shower trays, and dental care supplies and equipment
- Instructional materials (for example, pamphlets and books)
- Isolation gowns, surgical gowns and masks
- Magnifying glasses
- Massage devices
- Medical alert bracelets and response systems
- Medical supplies defined as drugs
- Medication boxes or medication dispensing equipment
- Menses products (for example, sanitary pads)
- Motorized lifts for a vehicle
- Orthopedic mattresses
- Personal computers and printers, tape recorders or video recorders
- Pulse tachometers
- Ramps that are affixed to the home

- Reachers and grabbers
- Reading glasses
- Saline or other solutions for the care of contact lenses
- Table foods
- Telephones, telephone alert systems, telephone arms or answering machines
- Tennis or gym shoes
- Thermometer covers
- Toothbrushes and toothettes
- Toys
- Washable or reusable incontinence undergarments
- Waterbeds
- White canes for the blind

Refer to [Noncovered Services](#) in the Billing the Member (Recipient) section for more information on how to execute notifying and billing the member for a noncovered item.

### **Add-ons and Upgrades**

An add-on is a noncovered item that can be added to a piece of covered equipment.

An upgrade is a piece of equipment with extra, more desirable features that substitutes for a less costly piece of equipment. MHCP will often cover the upgraded item for members who meet criteria if authorization is obtained. For example, MHCP covers manual hospital beds without authorization for members with positioning needs. A semi-electric hospital bed would be an upgrade unless the member meets MHCP coverage criteria.

If MHCP pays for the equipment, a provider can bill a member for a noncovered add-on. Refer to the [MHCP Advance Recipient Notice \(DHS-3640\) \(PDF\)](#). If MHCP makes any payment toward the equipment, the provider cannot bill the member or accept payment on behalf of the member for the difference between the covered equipment and the upgraded equipment. Refer to [Noncovered Services](#) in the Billing the Member (Recipient) section.

MHCP will not pay for repairs or maintenance to noncovered add-ons or upgraded equipment.

### **Provider-Initiated Upgrades**

Medical equipment that has features that go beyond what is medically necessary are considered upgrades. Providers may choose to supply upgraded equipment but charge MHCP for the non-upgraded item. The reason for this may be that the provider chooses to carry only upgraded equipment to reduce the costs of maintaining a broader inventory of models or replacement parts. Upgrades must be medically appropriate for the member's medical condition and the purpose of the physician's orders. An example of an upgrade is a standard hospital bed with a mahogany headboard and footboard rather than a plastic headboard and footboard.

The member may not be billed for the provider-initiated upgrades. If the provider chooses to supply upgraded equipment, the provider chooses to accept the MHCP payment for the non-upgraded item as payment in full.

When billing for a provider-initiated upgraded item, the claim must include only the charge and the HCPCS code for the non-upgraded item. The HCPCS code for the non-upgraded item must be accompanied by the GL modifier (medically unnecessary upgrade provided instead of the standard item, no charge). In the narrative field of the claim, specify the make and model of the item actually furnished, and describe why the item is an upgrade.

If prior authorization is needed for the non-upgraded item, submit the request for the HCPCS code of the non-upgraded item using the GL modifier. Include all required documentation for the medically necessary (non-upgraded) item and specify the make and model of the item that will actually be furnished. Describe why this item is an upgrade.

If repairs are needed to a provider-initiated upgraded item, MHCP will only pay for the repairs that might reasonably be required if the non-upgraded item had been provided unless the upgraded item is now medically necessary. For example, if a standard hospital bed was ordered and a semi-electric bed was provided as a provider-initiated upgrade, MHCP will pay for repairs to a broken caster, but would not reasonably require repair to a motor. If there has been a change in the member's condition, so that the semi-electric bed is now medically necessary, MHCP will pay for the repairs. If the repair would not be reasonably required by the medically necessary item, the provider must repair the upgraded item but cannot bill MHCP or the member for the repairs.

### **Billing and Documentation**

Follow the general billing information in the [Billing Policy](#) section of the manual. Additional information about billing of specific items can be found in the policy section for those items. The [Medical Supply coverage guide \(PDF\)](#) may have additional information.

### **Supplier Documentation**

The medical supplier must have the following information on file (additional details about each requirement can be found under this bulleted list):

- An order from the treating practitioner
- Documentation of the face-to-face encounter (when necessary)
- Member's diagnosis from the testing physician
- Any information required for use of specific modifiers or attestation statements
- Adequate information to assure that coverage criteria for an item have been met
- A medical record with information adequately supporting the medical necessity for the item
- Proof of delivery documentation

### **Orders**

MHCP requires an order from a treating practitioner for all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). Treating practitioners can include: physicians, physician assistants, or advanced practice nurses. Ordering practitioners must be working within their scope of practice. Specific policies may have different treating practitioners allowed to prescribe, review each policy for specific details. MHCP accepts the following order types according to Medicare guidelines.

### **New Order**

A new order is needed in the following circumstances:

- All new purchases and new rentals
- Whenever there is a change to an order from the treating practitioner
- Anytime an item is replaced
- When there is a change in supplier (when the new supplier does not have access to the previous order)
- Annually for supplies unless a specific product or policies requires one more frequently

### **Standard Written Order (SWO)**

This order must be communicated to the supplier before claim submission. This order can be used for all DMEPOS items except where Medicare requires a written order prior to delivery (WOPD). A SWO must contain the following according to MHCP policy:

- Beneficiary's name or MHCP member number
- Order date (signature date will count if before date of service)
- General description of the item (including all accessories or concurrent items) which can include any one of the following:
  - General description
  - HCPCS code
  - HCPCS code narrative
  - Brand name or model number
- Expected length of need\*
- Quantity to be dispensed
- Treating practitioner's name or NPI
- Treating practitioner's signature

\*Expected length of need is included as a requirement due to Minnesota Rule 9505.2175, subpart 5. This is not included in Medicare guidelines for SWO and WOPD but is required when billing MHCP.

### **Written Order Prior to Delivery (WOPD)**

- WOPD must be used according to MHCP guidelines.
- WOPD must follow the requirements under SWO.
- A WOPD is a completed SWO that is communicated to the DMEPOS supplier before delivery of the item.
- The date of the WOPD shall be on or before the date of delivery.
- A WOPD must be completed within six months following the required face-to-face encounter.

### **Face-to-Face Rule for Durable Medical Equipment, Appliances and Supplies**

#### **General Provisions**

- MHCP members are required to have a face-to-face encounter with a physician or certain authorized non-physician practitioners within the six months before ordering certain medical equipment, appliances and supplies.
- Non-physician practitioners authorized to conduct face-to-face encounters include physician assistants working under the supervision of a physician, nurse practitioners, and clinical nurse specialists.
- Nurse midwives, audiologists, and podiatrists are not authorized to conduct the face-to-face encounter.
- DME items that are subject to the face-to-face requirement by Medicare are also subject to the requirement by MHCP. A list of items subject to the face-to-face requirement may be found in Chapter 3 of the DME MAC Jurisdiction B Supplier Manual.
- Face-to-face encounters may occur through telehealth. Review Medicaid's [Telehealth](#) webpage for more information.
- The requirement applies to items covered by managed care organizations.

#### **Face-to-Face Documentation**

Providers must maintain written or electronic documentation of face-to-face encounters on file and available to DHS upon request. Documentation must include:

- The identity of the physician or non-physician practitioner who conducted the face-to-face encounter. Non-physician practitioners are authorized to complete the documentation requirements.
- The date of the face-to-face encounter
- The specific diagnosis or medical condition that was the reason for the face-to-face encounter and ordered service

Documentation of face-to-face encounters may be included in clinical and progress notes and discharge summaries. Documentation for the medical supplier's records may be copies of physician or non-physician practitioner notes, documentation of a phone call with the physician or non-physician practitioner to confirm the face-to-face encounter or a written summary from the physician or non-physician practitioner.

### **Ongoing Services**

Ongoing services are not subject to the face-to-face rule. A face-to-face encounter is only required for new medical equipment, supplies or appliances.

### **Financial Implications**

Payment for services can be subject to payment recovery if a timely face-to-face encounter was not documented. Review the [Code of Federal Regulations, title 42, part 440](#) for more information.

### **Medical Records**

Medical records must contain the following information:

- The medical condition which provides the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).
- The diagnosis and other pertinent information including duration of the condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitation, other therapeutic interventions and results, past experience with related item, and the like.
- The clinical information that supports the medical necessity for the item and substantiates the information on a supplier prepared statement or physician attestation (if applicable).
- Medical records are not limited to the physician's office records. They may include hospital, nursing home or home health agency records, or records from medical professionals such as nurses, physical or occupational therapists, prosthetists and other.

DHS may request this information in select cases. The supplier is liable for the dollar amount involved if the information is not received or does not substantiate medical necessity.

Neither a physician's order, a supplier's prepared statement, nor a physician attestation by itself provides sufficient documentation of medical necessity.

### **Proof of delivery**

Provide proof of delivery in any of the following methods:

#### **Method 1: Supplier delivers items directly to the member or authorized representative**

- The delivery slip must be signed and dated by the member or authorized representative to verify the DME or supply item was received.
- The date of the signature on the delivery slip must be the date DME or supply was received by the member or authorized representative.
- The delivery slip must include the member's name, quantity, a detailed description of the items delivered, brand name and serial number (if applicable).
- The date of service on the claim must match the date on the delivery slip.

**Date of service exception:** If the DME item is delivered to a member in a hospital up to two days before discharge (home) and for the benefit of the member for the purpose of fitting or training of the member in its use, the supplier must bill the date of service on the claim as the date of discharge (home) and must use place of service "12" (home).

**Method 2: Supplier delivers certain items without the member's signature of receipt**

- For medical supplies that are not vulnerable to damage by weather and that do not require fitting or training, the member or authorized representative may consent in advance to waive in-person signature.
- The consent must be in writing and must specify a preferred location at the member's residence for supplies to be left.
- The delivery slip must be signed by the person delivering the goods, and must specify the date, time and place of delivery.
- The delivery slip must include the member's name, a detailed description of the items delivered, quantity, brand name and serial number (if applicable).
- MHCP will not pay for items reported damaged or missing. Providers are encouraged to talk to their insurers to discuss liability for replacing items if a member reports the product damaged or missing.
- The date of service on the claim must be the date on the delivery slip.

**Method 3: Supplier uses a delivery or shipping service to deliver items**

- Acceptable proof of delivery includes the delivery service's tracking slip and the supplier's shipping invoice.
- The supplier's shipping invoice must include the member's name, quantity, detailed description of the items delivered, brand name, serial number (if applicable), and delivery service's package identification number associated with the member's packages.
- The delivery service's tracking slip must reference the member's packages, delivery address and the corresponding package identification number given by the delivery service.
- The item will be denied and any payment will be recouped without the delivery service's tracking slip that identifies each individual package with a unique identification number and delivery address.
- The item will be denied and payment will be recouped when the member denies receipt of an item, unless the supplier maintains a detailed shipping invoice and the delivery service's tracking log.
- Mail order DME or supply items: The date of service on the claim must be the shipping date.

**Method 4: Items delivered to an LTC facility on behalf of the member**

Proof of delivery must be maintained in the supplier's records as described in Methods 1 and 2. Suppliers must work with the LTC facility staff to implement inventory control to ensure that:

- LTC facility received delivery and was provided with receipt of what was delivered.
- Supplies were identified and retained for use only by intended members.
- Suppliers receive proof of delivery from the LTC facility.
- Medical records in the LTC facility must document use of all supplies and items billed to MHCP. Documentation may be in the nurse's notes or a special treatment record or form.
- The date of service on the claim must be the date the DME was received by the LTC facility if delivered by the supplier, or the shipping date if the supplier used the delivery or shipping service.

**Date of service exception:** if the DME is delivered to a member in an LTC facility up to two days before discharge (home) and for the benefit of the member for the purpose of fitting or training of the member in its use, the supplier must bill the date of service on the claim as the date of discharge (home) and must use place of service "12" (home).

All services that do not have appropriate proof of delivery from the supplier will be denied and all payments must be returned to DHS. Suppliers who consistently do not provide documentation to support their services will be referred to the DHS Surveillance and Integrity Review Systems (SIRS) Unit and the Office of the Attorney General.

## Hospitalized Members

Except as noted in the Supplier Documentation section, do not bill for medical equipment and supplies ordered for subsequent use in the member's home before the date of the member's discharge (home). This includes drugs, supplies used with the DME or prosthetic devices, surgical dressings, urological supplies, or ostomy supplies applied in the hospital including items worn home by the member.

Suppliers are responsible for delivering the DME to the member's home following discharge.

## Dispensing of Equipment and Supplies

Follow these guidelines when dispensing equipment and supplies:

- Dispense no more than one month of supplies at a time unless specifically permitted by coverage policy.
- Requests must come from the member or an authorized representative each time additional supplies are needed.
- It is acceptable for medical supply providers to call the member to verify a re-order.
- Automatically shipping supplies without an indication from the member or the member's authorized representative confirmation is not permitted.
- Do not ship more supplies than are necessary for the member. (Example: If the member will have a quantity of 10 left of a supply at the end of a month of supplies, you must subtract 10 from the re-order)
- Education must be provided to members regarding safety and proper use of supplies and equipment.
- Providers must ensure equipment is either assembled or clear instructions available when assembly cannot be completed.
- A 10-day shipping window is allowed for supplies. Please note "10-day shipping window" on the claim.

## Authorization Requirements

The provider must obtain authorization when required. Refer to [General Authorization Criteria and Documentation Requirements](#) to review all general criteria that are required for authorization requests. Review specific DME policies and the [Medical Supply coverage guide \(PDF\)](#) for questions about when authorization is required.

Submit authorization request and required documentation to the [authorization medical review agent](#).

- The provider may not request or accept payment from the member for any service for which the required authorization was not obtained. Refer to the [Billing the Member \(Recipient\)](#) section of the MHCP Provider Manual.
- List all add-on items on separate lines on the authorization request, even if the individual item does not require authorization. List each item by HCPCS code, appropriate modifier, quantity and charge.
  - MHCP will not authorize more units per line than are allowed by Medicare's Medically Unlikely Edits (MUEs). Refer to the Centers for Medicare & Medicaid [Medicare NCCI Medically Unlikely Edits \(MUEs\)](#) webpage for more information.
- When requesting multiple items that are different but require the same miscellaneous code, list each item on a separate line of the authorization request. A unique description of each item must be entered into the model number field for each line. The unique description may be a model number or narrative description up to 20 characters.

- Documentation must address the member's medical need. For prosthetics, orthotics, mobility devices and similar items that include multiple components with distinct HCPCS codes, list the HCPCS for each accessory on its own line.
- When authorization is required, list all requested parts or accessories on the authorization request. If approved, the approved rate will include all requested and approved parts or accessories.
- Prior authorization is required for all repairs when parts and labor total over \$400 for DME (other than wheelchairs).
- Modifiers KH, KI and KJ apply to all authorization requests for a capped rental item. Each K modifier must be on a separate line on the authorization request.
- Authorization is required for all durable medical equipment purchase and rental when the same HCPCS code has been provided to the member in the past 16 months.
- Authorization is required for new equipment that is provided due to the same equipment not lasting the reasonable five-year lifetime.
- Authorization is required for all supply requests over the allotted units allowed.

### **Authorization requests for typically noncovered items**

Authorization can be requested for any piece of medical equipment, supply, prosthetic, or orthotic that is typically considered a non-covered item. The item must be medically necessary.

Submit the authorization request and required documentation to the [authorization medical review agent](#).

Documentation must demonstrate the item meets all the following criteria:

- Medically necessary, as determined by prevailing medical community standards or customary practice and usage
- Appropriate and effective for the member's medical needs
- Timely, considering the nature and present medical condition of the member
- Provided by a provider with the appropriate credential
- The least expensive, appropriate alternative available
- An effective and appropriate use of MHCP funds
- Not investigative, or investigative but should be approved for compassionate use
- Suitable for use in the member's home or any non-institutional setting in which normal life activities take place
- Is generally not useful in the absence of an illness, injury, or disability
- Is provided to correct or accommodate a physiological disorder of physical condition or is generally used primarily for a medical purpose.

### **Billing**

Providers are responsible to [coordinate services](#). Refer to the [Billing Policy Overview](#) section of [Provider Basics](#) for general billing information.

### **General billing information**

- Use [MN-ITS 837P Professional](#). Refer to the [MN-ITS User Guide for DME/Med Supply/Prosthetics/Orthotics](#) for general billing requirements and guidance when submitting claims.
- Report the name and NPI number of the actively enrolled ordering MHCP provider in the Other Provider Types section of the MN-ITS Interactive 837P claim.
- Use current HCPCS procedure codes and modifiers. To determine the appropriate HCPCS code to use with a covered service, refer to the Medicare Pricing, Data Analysis and Coding (PDAC) Palmetto GBA [Durable Medical Equipment Coding System](#) webpage.

- If the member has Medicare, MHCP will pay the deductible or coinsurance on any units for which Medicare made payment. Any units for which Medicare denies payment must meet MHCP quantity and authorization requirements. Authorization can be retroactively requested.
- If a claim does not crossover from Medicare, and you received payment from Medicare, submit a claim to MHCP for the coinsurance or deductible. Complete the claim exactly as Medicare requires and include the member's MHCP ID number and your NPI number.
- When the model number field is used, do not use the Notes field on the Services tab in MN-ITS. Use the Claim Notes field on the Claim Information tab.
- The submitted charge must be the usual and customary charge, inclusive of all applicable shipping costs and sales taxes.
- Dispense and bill only a one-month supply.
- Durable medical equipment is expected to serve the member for at least five years. If a device is stolen or damaged beyond repair, a replacement device may be covered with authorization.
- All rental months, whether paid fee-for-service or by a prepaid MHCP health plan, count toward the purchase price unless there is a break in continuous use. A break in continuous use is defined as a period of 60 days or more during which the provider has removed the equipment from the member's home, or the member is not using the equipment because of an inpatient hospital or skilled nursing facility stay.
- Durable medical equipment determined by Medicare to require frequent and substantial servicing is not subject to a capped rental limit.

#### **Billing miscellaneous and manually priced HCPCS codes**

- Do not use miscellaneous codes when a more appropriate code is available.
- A Manufacturer's Suggested Retail Price (MSRP) document from the manufacturer is required. If MSRP is not available we will accept an invoice from the manufacturer.
- Submit the pricing document as an attachment as described in the [Electronic Claim Attachments](#) section.
- Clearly indicate which item on the pricing documentation corresponds to each item on the claim.
- Do not block out or modify the price list or invoice but you may star or circle.

#### **Billing prior authorization claims and services**

- Attach the MSRP for all HCPCS codes that do not have a set fee schedule rate dated within three months of the authorization request. If MSRP is not available, we will accept an invoice from the manufacturer. Documentation that is not an invoice, for example a quote, is assumed to be MSRP. Clearly indicate each item being requested. Do not modify, alter or change the pricing documentation but you may star or circle the item.
- Submit the pricing document as an attachment as described in the [Electronic Claim Attachments](#) section
- It is permitted to submit one claim with HCPCS codes for items on the prior authorization that have a set fee schedule rate and do not require manual pricing. Then submit a second claim for the items from the prior authorization that require manual pricing. Enter the authorization number in the authorization field for each line on both claims.
- If authorization is required, the claim must match HCPCS code, modifiers and description or model number as noted on the authorization letter. Refer to the [MN-ITS User Guide](#) or for batch billers, the HIPAA Implementation Guide and the [Minnesota Uniform Companion Guide \(PDF\)](#) for field requirements.
- Bill services approved through the authorization process on a separate claim from services not requiring authorization. Example: Submit one claim (no authorization required) for the number of units up to the quantity limit. Submit another claim with the prior authorization for the additional quantity dispensed over the quantity limit.
- Enter the authorization number in the authorization field for each line.

## Modifiers

- Use a modifier to indicate purchase, rental, repair or replacement of a part or item. Additional modifiers may be appropriate depending on the item or service.
- For capped rental items that are billed as rental, use modifiers KH for the first month, KI for the second and third months, and KJ for months 4 through 13 of rental. A new capped rental period is allowed if over 60 days have lapsed from the previous payment or if a new provider takes over the rental.
- Rentals will only be paid up to the allowable amount.
- Follow Medicare guidelines for when to use modifiers such as AU, AV, AW, KC, KE, KF, KL, KM and KN. When using these or other modifiers, providers must also include modifier NU, RR, RA, or RB to be reimbursed at the appropriate rate.
- Follow Medicaid NCCI edit requirements for modifiers when used to bypass an NCCI edit.

## Billing for repairs to patient-owned equipment

- Bill repairs using modifier RB and the HCPCS code of the item being repaired when making repairs to equipment.
- Use modifier RA and the HCPCS code of the accessory being replaced when replacing an accessory on a piece of equipment.
- The submitted charge for a repair must include all materials.
- Do not bill repairs over a span of dates.
- When billing labor for repairs, specify the number of units and the rate. Do not bill for setup and delivery, or for service calls that do not involve actual labor time for repairs.
- If the member-owned equipment was not originally billed to MHCP, a note of medical necessity from the doctor must be obtained to certify the equipment is needed.

## What not to bill

- The cost of shipping, handling or freight charges are not reimbursable. If these charges are included on the invoice or as part of the Manufacturer's Suggested Retail Price, they will be excluded from the payment.
- Do not bill for service calls that do not involve actual labor time for repairs.
- Do not bill for sales tax. Refer to the Minnesota Department of Revenue's [Durable Medical Equipment Sales Tax Fact Sheet 117B \(PDF\)](#) for additional information.
- Delivery and set-up costs are included in the MHCP maximum allowable payment and may not be separately billed to MHCP or the member
- Pick-up and delivery costs related to equipment repairs and return of rental equipment

## Reimbursement

- Reimbursement for all rental items will cap at the purchase price.
- All rental payments, including payments received from the member or TPL, apply to the purchase price.
- Do not continue to bill monthly rental after the maximum rate has been reached.
- After MHCP purchases the medical equipment or supply for a member, the item is the member's property.

## Legal References

[Minnesota Statutes 256B.04](#), subdivision 14

[Minnesota Statutes 256B.0625](#), subdivision 31

[Minnesota Statutes 256D.03](#), subdivision 4 (5); (8)

[Minnesota Statutes 297A.67](#), subdivision 7

[Minnesota Rules 9505.0310](#)

[Minnesota Rules 9549.0020](#)

[Minnesota Rules 9505.0365](#)

[Minnesota Rules 9505.0445](#)

[Minnesota Rules 9505.2190](#), subpart 1

[Minnesota Rules 9505.2197](#)

[Code of Federal Regulations, title 42, section 410.10 \(g\)\(h\)](#)

[Code of Federal Regulations, title 42, section 410.36](#)