Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 60—Durable Medical Equipment Program

Title		Page
13 CSR 70-60.010	Durable Medical Equipment Program	3

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
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13 CSR 70-60.010 Durable Medical Equipment Program

PURPOSE: This rule establishes the regulatory basis for the administration of the Medicaid durable medical equipment program, designation of professional persons who may dispense durable medical equipment and the method of reimbursement for durable medical equipment. This rule provides for such methods and procedures relating to the utilization of, and the payment for, care and services available under the Medicaid program as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. Specific details of the conditions for provider participation, criteria and methodology of provider reimbursement, recipient eligibility and amount, duration and scope of services covered are included in the durable medical equipment provider program manual which is incorporated by reference in this rule and available at the website www.dss.mo.gov/dms.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The Medicaid durable medical equipment (DME) program shall be administered by the Department of Social Services, Division of Medical Services. The services and items covered and not covered, the program limitations and the maximum allowable fees for all covered services shall be determined by the Department of Social Services, Division of Medical Services and shall be included in the DME provider manual, which is incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website at www. dss.mo.gov/dms, July 15, 2005. This rule does not incorporate any subsequent amendments or additions.

(2) Persons Eligible. Any person who is eligible for Title XIX benefits as determined by the Family Support Division is eligible for DME when the DME is medically necessary as determined by the treating physician or advanced practice nurse in a collaborative practice arrangement. Covered services are limited as specified in section (6) of this rule.

(3) Reimbursement. Payment will be made for each unit of service or item provided in accordance with the fee schedule determined by the Division of Medical Services. Reimbursement will not exceed the lesser of the maximum allowed amount determined by the Division of Medical Services or the provider's billed charge. Reimbursement for DME services is made on a fee-for-service basis. The Medicaid maximum allowable fee for a unit of service has been determined by the Division of Medical Services to be a reasonable fee, consistent with efficiency, economy, and quality of care. Sales tax is not covered by Medicaid, nor can it be billed to the recipient. Providers must accept the Medicaid payment as the full and complete payment and may not accept additional payment from the recipient. Charges for shipping, freight, COD, handling, delivery and pickup are included in the reimbursement for items covered under the DME program and are not billable to the Medicaid recipient.

(4) Definition for Durable Medical Equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. All requirements of the definition must be met in order for the equipment to be covered by Medicaid.

(5) Provider Participation.

(A) The following types of providers may be reimbursed by Medicaid for items covered under the DME program if they are enrolled Medicaid providers: rental and sales providers, prosthetic fabricators, rehabilitation centers, orthotic fabricators, physicians (includes M.D., D.O., podiatrists—may dispense orthotic devices and artificial larynx), advanced practice nurses in a collaborative practice arrangement, pharmacies and hospitals.

(B) The enrolled Medicaid provider shall agree to:

1. Keep any records necessary to disclose the extent of services the provider furnishes to recipients; and

2. On request furnish to the Medicaid agency or State Medicaid Fraud Control Unit any information regarding payments claimed by the provider for furnishing services under the plan.

(6) Covered Services. It is the provider's responsibility to determine the coverage benefits for a Medicaid eligible recipient based on his or her type of assistance as outlined in the DME manual. Reimbursement will be made to qualified participating DME providers only for DME items, determined by the recipient's treating physician or advanced practice nurse in a collaborative practice arrangement to be medically necessary. Covered services include the following items: prosthetics, excluding an artificial larynx; ostomy supplies; diabetic supplies and equipment; oxygen and respiratory equipment, excluding CPAPS, BiPAPs, nebulizers, IPPB machines, humidification items, suction pumps and apnea monitors; and wheelchairs, excluding wheelchair accessories and scooters. Covered services for Medicaid eligible needy children or person receiving Medicaid under a category of assistance for pregnant women or the blind shall include but not be limited to: prosthetics; orthotics; oxygen and respiratory care equipment; parenteral nutrition; ostomy supplies; diabetic supplies and equipment; decubitus care equipment; wheelchairs; wheelchair accessories and scooters; augmentative communication devices; and hospital beds. Specific procedure codes that are covered under the DME program are listed in Section 19 of the DME provider manual, which is incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65102, at its website at www.dss.mo.gov/dms, July 15, 2005. This rule does not incorporate any subsequent amendment or additions. These items must be for use in the recipient's home when ordered in writing by the recipient's physician or advanced practice nurse in a collaborative practice arrangement. Although an item is classified as DME, it may not be covered in every instance. Coverage is based on the fact that the item is reasonable and necessary for treatment of the illness or injury, or to improve the functioning of a malformed or permanently inoperative body part and the

equipment meets the definition of DME. Even though a DME item may serve some useful, medical purpose, consideration must be given by the physician or advanced practice nurse in a collaborative arrangement and the DME supplier to what extent, if any, it is reasonable for Medicaid to pay for the item as opposed to another realistically feasible alternative pattern of care. Consideration should be given by the physician or advanced practice nurse in a collaborative practice arrangement and the DME supplier as to whether the item serves essentially the same purpose as equipment already available to the recipient. If two (2) different items each meet the need of the recipient, the less expensive item must be employed, all other conditions being equal.

(7) Documentation. The DME provider and physician or advanced practice nurse in a collaborative practice arrangement shall document how they determined what was the least expensive, feasible alternative for treatment of the illness or injury, or to improve the functioning of a malformed or permanently inoperative body part.

(8) Durable medical equipment for recipients who are in a nursing facility or inpatient hospital. DME is not covered for those recipients residing in a nursing home. DME is included in the nursing home per diem rate and not paid for separately with the exception of custom and power wheelchairs, prosthetic devices, and volume ventilators. DME that is used while the recipient is in inpatient hospital care is not paid for separately under the DME program. These costs are recognized as part of the hospital's inpatient per diem rate.

(9) Non-Covered Items. Missouri Medicaid does not cover items which primarily serve the following purposes: personal comfort, convenience, education, hygiene, safety, cosmetic, new equipment of unproven value, and equipment of questionable current usefulness or therapeutic value. Specific items which are generally not covered can be found in Section 13.32 of the DME manual. Examples of non-covered items are: air conditioners, computers (unless determined to be used for an augmentative communication device), electric bathtub lifts, elevators, furniture, toys, home modifications, refrigerators, seat lift chairs, stair lifts or glides, treadmill, water softening systems, wheelchair lifts, wheelchair ramps, whirlpool tubs or pumps.

(10) Medicare/Medicaid Crossovers. For recipients having both Medicare and Medicaid eligibility, the state Medicaid program pays the lesser of the amounts indicated by Medicare to be deductible and/or coinsurance due on the Medicare allowed amount or the difference between the amount paid by Medicare and the Medicaid allowed amount.

(11) Records Retention. These records must be retained for five (5) years from the date of service. Fiscal and medical records coincide with and fully document services billed to the Medicaid agency. Providers must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal or retain adequate documentation for services billed to the Medicaid program, as specified above, is a violation of this regulation.

AUTHORITY: sections 208.153 and 208.201, RSMo 2000. Original rule filed Nov. 1, 2002, effective April 30, 2003. Emergency amendment filed Aug. 11, 2005, effective Sept. 11, 2005, expired Feb. 27, 2006. Amended: Filed June 15, 2005, effective Dec. 30, 2005.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991 and 208.201, RSMo 1987.*