

	<p>Durable Medical Equipment (DME) Service Procedure</p>	
<p>Procedure # 4358</p>	<p>Categories Clinical → Administrative</p>	<p>This Procedure Applies To: Texas Children's Health Plan</p>
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PROCEDURE STATEMENT: Texas Children’s Health Plan (TCHP) provides access to durable medical equipment (DME) as needed by members and covered by benefits plan. This procedure applies to all lines of business.

PROCEDURE

1. Choice of Provider:

1.1. The member has the right to choose a DME/medical supply provider and change providers. If the member changes providers, TCHP must receive a change of provider letter with a new Physician Order. The member or legally appointed representative must sign and date the letter, which must include the name of the previous provider and the effective date for the change. The member 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 TCHP receives the change of provider letter and the new Order Form.

2. Benefit Limitations:

- 2.1. Frequency of monthly billing – DME **monthly** limits will be applied every 27 days.
- 2.2. Texas Children’s Health Plan applies benefit limitations for DME Supplies and Equipment per the current Texas Medicaid Healthcare & Partnership Manual (TMHP), except as noted in Table A below for the STAR and STAR Kids Product lines.
 - 2.2.1. If a DME item for a STAR or STAR Kids member who is 20 years or younger requires prior authorization, a provider may justify the medical necessity of exceeding the TMHP limitation in their prior authorization request.
 - 2.2.2. If a DME item for a STAR or STAR Kids member who is 20 years of age or younger does not require a prior authorization, a provider may submit a prior authorization justifying the medical necessity of exceeding the benefit limitation to the TCHP Utilization Management department.
 - 2.2.3. TCHP will request documentation to support medical necessity as per the current Texas Medicaid Provider Procedure Manual (TMPPM) for the item requested.

- 2.3. Texas Children's Health Plan applies benefit limitations for covered DME Supplies and Equipment per the current TMHP Manual, except as noted in Table A below for the CHIP Product lines.
- 2.3.1. If a covered DME item for a CHIP member requires prior authorization, a provider may justify the medical necessity of exceeding the TMHP limitation in their prior authorization request.
- 2.3.2 Upon the receipt of a prior authorization request for a DME item requiring prior authorization for a CHIP member, the UM staff:
 - 2.3.3 Assess Medical Necessity for the DME item using guidelines set forth by TCHP.
 - 2.3.3.1 Initiate search for previous DME authorizations in system.
 - 2.3.3.2 If multiple authorizations for DME exist, evaluate specific HCPCS and/or CPT Codes and ask Claims Department to verify what has been paid out for DME on member's behalf for the current enrollment period.
 - 2.3.3.2.1 If unable to obtain codes from authorization in system, contact agency to get correct billing codes from them.
 - 2.3.3.3 Once previous DME payout is calculated:
 - 2.3.3.3.1 Subtract the DME payout from the Benefit Limit to calculate remaining benefit.
 - 2.3.3.3.2 On the authorization, document medical necessity and cost of high dollar DME item.
 - 2.3.3.3.3 If, at any time, you are unsure of the medical necessity of the requested DME item, refer request to the Medical Director.
 - 2.3.3.3.4 If remaining benefit covers the cost of the DME item and it meets TCHP medical necessity guidelines, approve the authorization and fax to requesting provider.
 - 2.3.3.3.5 If the remaining benefit dollars do not cover the cost of the item requested, refer request to Medical Director for review.
 - 2.3.3.3.5.1 If medical necessity is met with Medical Director Approval, approve through the end of benefit coverage.
 - 2.3.3.3.5.2 On the claims payment screen, indicate the potential shortage of DME benefits payment through use of hold code.
 - 2.3.3.3.5.3 Document in authorization notes, the estimated remaining benefit, the cost of the item, and the amount that would be the responsibility of the insured.
 - 2.3.3.3.5.4 Indicate in the approval correspondence that benefits may be exhausted during the course of the treatment/services requested.
 - 2.3.3.3.6 Follow the TCHP notification procedure.

- 2.3.4 If a DME item for a CHIP member does not require a prior authorization, a provider may submit a prior authorization justifying the medical necessity of exceeding the benefit limitation to the TCHP Utilization Management department.
 - 2.3.4.1 TCHP will request documentation to support medical necessity as per the current Texas Medicaid Provider Procedure Manual for the item requested.
3. Request for prior authorization for continued services with out-of-network DME providers.
 - 3.1. Supplies related to tracheostomy and gastrostomy status (ventilators, feeding tube pumps, etc.) may approved for up to 90 days if any of the following apply:
 - 3.1.1. The provider was in-network at the time of initial rental request
 - 3.1.2. The member received the requested services through a prior authorization from either another Managed Care Organization (MCO) or Fee for Service (FFS) provider
 - 3.2. General soft medical supplies, off the shelf DME equipment, enteral feeding formulas and supplements, catheters, dietary supplements, ostomy supplies, oxygen and oxygen concentrators, etc. are available through in-network providers and do not meet criteria for authorization of out-of-network services.
4. Incontinence supplies (diapers, wipes, underpads) require prior authorization for members age 3 and younger.
 - 4.1. Incontinence supplies may be considered for members age 3 and younger with a medical condition that results in increased urine or stool output beyond what is typical for this age group, including but not limited to:
 - 4.1.1. Short bowel syndrome, Crohn's disease, celiac disease, diabetes insipidus, radiation enteritis, or certain metabolic conditions.
 - 4.1.2. Quantity limitations per TMPPM apply to this age group: diapers (240 per month), wipes (2 boxes per month), and underpads (120 per month).
 - 4.1.2.1.1. Wipes are for members receiving diapers/briefs/pull-ons and underpads are for members receiving diapers/briefs/pull-ons/liners/urine or bowel collection devices.
 - 4.1.2.1.2. Gloves used to change diapers and briefs are not considered medically necessary unless the member has skin breakdown or a documented disease that can be transmitted through urine or stool.
5. Prior authorization is required over the limit requests: diapers (more than 240 per month), wipes (more than 2 boxes per month), and underpads (more than 120 per month).
 - 5.1. Wipes are for members receiving diapers/briefs/pull-ons and underpads are for members receiving diapers/briefs/pull-ons/liners/urine or bowel collection devices.
6. Requests that do not meet the criteria established by this procedure will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

PROCEDURE

7. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

Table A: TCHP Exceptions to TMHP DME Limits

CPT Code	Description	TMHP Limit	TCHP Limit
A4310	Insertion tray without drainage bag and without catheter (accessories only)	2 per month	30 per month
A4312	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone	2 per month	30 per month
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all cone	2 per month	30 per month
A4332	Lubricant, individual sterile packet, each	50 per month	180 per month
A4338	Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each	2 per month	30 per month
A4344	Indwelling catheter, Foley type, two-way, all silicone, each	2 per month	30 per month
A4351	Intermittent Catheters - must be accompanied with modifier SC when a hydrophilic catheter is used.	150 per month	180 per month
A4352	Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each	150 per month	180 per month
A4353	Intermittent urinary catheter, with insertion supplies; hydrophilic catheters	150 per month	180 per month
A4605	Tracheal suction catheter, closed System, each	10 per month	30 per month
A4628	Oropharyngeal suction catheter	2 per month	4 per month
B9998 U2	Nonobturated gastrostomy or jejunostomy tube with insertion supplies and extensions	2 per rolling year	6 per rolling year

RELATED DOCUMENTS:

[DME Service Policy](#)

REFERENCES:

Government Agency, Medical Society, and Other Publications:

Texas Medicaid Provider Procedure Manual – Accessed October 7, 2022
<https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/archives/2022-10-TMPPM.pdf>

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