Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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MaineCare Services
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TTY: Dial 711 (Maine Relay)

DATE: October 31, 2023

TO: Interested Parties

FROM: Michelle Probert, Director, Office of MaineCare Services

SUBJECT: 10-144 C.M.R. Chapter 101, Chapter II, Section 60, Medical Supplies and Durable Medical Equipment

This letter gives notice of adopted rule: 10-144 C.M.R. ch. 101, MaineCare Benefits Manual (the "MBM"), Chapter II, Section 60, Medical Supplies and Durable Medical Equipment.

This adopted rule makes the following changes. The citations used below reflect the provisions in the adopted rule, unless otherwise specified.

- Adds a definition for "qualified provider" and indicates that qualified providers, rather than specific provider types, can prescribe and conduct face-to-face evaluations. This change aligns with Medicare's requirements and will ensure the policy remains current with evolving federal and state requirements.

- Deletes the definition of "Providers of Medical Supplies and Durable Medical Equipment" and moved most of the definition into Section 60.04, Provider Requirements, because this is a substantive provision and more than a definition. The Department adds an exception to the requirement of having a storefront in Maine or within 15 miles of the border if the Department, in its sole discretion, determines that waiving that requirement is in the best interest of the MaineCare program. Additionally, Section 60.04(5) is taken from the former Section 60.01-12(C).

- Renumbers the current Section 60.05, Policies and Procedures, to 60.06, Policies and Procedures.

- Creates Section 60.06-1, Face-to-Face Encounter, which largely contains content from current Section 60.05. The Department adopts a few changes to the content, such as providing that the written order may be, but does not have to be, prescribed by the provider who performed the face-to-face encounter.

- Removes the requirement in 60.06-1, Face-to-Face Encounters, that DME providers must inform members prior to the provision of DME that is not covered by MaineCare that the member will be responsible for payment because this requirement is already included in 10-144 C.M.R., Chapter 101, Chapter I, Section 1.

- Re-names and re-numbers Section 60.05-1, Requirements, to Section 60.06-2, Medical Supplies and DME Requirements.

- Allows qualified providers, rather than a physician or PCP, to prescribe medical supplies and DME in Section 60.06-2(B) because different provider types can prescribe medical supplies and DME within their scope of practice.

- Removes current Section 60.06-2(I) which contains information regarding prior authorization (PA) and the Department's Health PAS Portal because it is already included elsewhere in the policy.

- Adds the requirement in Section 60.06-2(I) that a physician or qualified provider must review a member's need for DME and supplies annually, as required by 42 CFR 440.70(b)(3)(iii).

- In Section 60.06-2(J), requires a "prescribing provider," rather than a "prescribing physician," to maintain the referenced documentation, including the name of the "qualified provider," rather than the "physician, nurse practitioner, physician assistant or clinical nurse specialist," who performed the face-to-face encounter.

- In Section 60.06-3(F), requires providers to retain, rather than submit, documentation that applicable equipment can freely pass through all entryways without the need for modification or, if applicable, that necessary modifications or structural changes occurred prior to the PA request. Medicare uses this policy, and it is reasonable for MaineCare to utilize this policy.

- Adds that the Department shall rent and/or purchase items consistent with Medicare practices in Section 60.06-4.

- In Section 60.06-7, Replacement of DME, moves the last sentence in the provision regarding when replacement will not be allowed, to the beginning of this provision and added a sentence that DME that is functioning properly will not be replaced unless a change in the member's condition requires a change of DME.

- In Section 60.06-8, to align with 42 CFR § 440.70, removes the requirement that medical supplies and DME may be provided to members residing in their own homes and clarifies that medical supplies and DME may be provided for use in any setting in which normal life activities take place, other than a hospital or any setting in which payment is or could be made under MaineCare for inpatient services that include room and board.

- In Section 60.06-9, clarifies that the regular rate of reimbursement for nursing facilities and intermediate care facilities for individuals with intellectual disabilities is intended to include DME upgrades and add-ons.

- Moves the content of former Section 60.06-2, Prior Authorization, into Section 60.07, Prior Authorization Requirements.

- Removes the current rule provision Section 60.06-2(2), Orthotics and Prosthetic DME, because it contains redundant requirements and unnecessary definitions.

- Moves the content from Section 60.05-8, Prosthetics, and Section 60.12(L), Orthotics & Prosthetics, to new Section 60.08-2, Orthotics and Prosthetics, and makes a few changes to clarify language.

- Adds Section 60.08-3, Augmentative and Alternative Communication Devices, requiring members to trial augmentative and alternative communication devices before the Department will rent or purchase the devices. It is standard industry practice for patients to trial these devices before purchasing, and

manufacturers and providers are accustomed to this. Currently, this is a PA-based requirement that is on the Department's website.

- Moves Section 60.12(Z) to Section 60.08-4, Specially Modified Foods and Formulas, which provides that specially modified foods and formulas are covered when the member has inborn errors of metabolism. The Department no longer allows members to receive specially modified foods and formulas when they have "a qualifying medical condition where the most effective and appropriate form of caloric or nutritional intake is orally" because it lacks specificity. Members will continue to be eligible for specially modified foods and formulas when they have inborn errors of metabolism.

- In Section 60.08-5, specifies that modifications and inserts for diabetic shoes are limited to a combined total of six units per member per rolling year, instead of per year.

- Adds coverage for breast milk bags with a limit of 120 units (bags) per member per rolling month in Section 60.08-14.

- Adds coverage for automatic blood pressure monitors with a limit of one unit per member per three calendar years in Section 60.08-15.

- Section 60.10, Reimbursement: The Department adopts the following changes to the reimbursement provision:
  - Retroactively to January 1, 2023, establishes reimbursement for all Medicare covered codes at 100% of the current Medicare fee schedule amount and adds an annual cost-of-living adjustment for the rates for all non-Medicare covered codes. These changes are permitted retroactively pursuant to 22 MRS 42(8) because they benefit MaineCare providers.
  - Clarifies that the Medicare rates are pulled from the Medicare DMEPOS Fee Schedule.
  - Moves the Incontinence Supplies reimbursement provision from the current Section 60.09-1(C) to Section 60.10-2. The Department adjusts the maximum amount allowed by MaineCare for incontinence supplies with an inflation adjustment based on the Consumer Price Index for All Urban Consumers for Medical Equipment and Supplies. This change will be retroactive to January 1, 2023, and is lawful pursuant to 22 M.R.S. 42(8) because the inflation adjustment benefits providers.
  - Adds Section 60.10-2 that contains criteria for providers to request incontinence supplies that are not on the MaineCare fee schedule.
  - Amends Section 60.10-6 provision related to the reimbursement of rental items, so that rental periods (except for oxygen) follow Medicare rental periods.
  - Modifies Section 60.10-7 to remove redundant information and to align oxygen rental requirements with current MaineCare practices.

  P.L. 2021, ch. 398, required the Department to align rate structures and fee schedules with Medicare. The current rule, which was effective in 2018, does already align most DME rate structures and fee schedules with Medicare; this final rule expands the alignment with Medicare, including adopting Medicare's rental period classifications and corresponding rental rates, and thus complies with P.L. 2021, ch. 398. These changes also ensure MaineCare's compliance with the Upper Payment Limit demonstration required by the Centers for Medicare & Medicaid Services and authorized by section 1903(i)(27) of the Social Security Act. This rulemaking also complies with P.L. 2021, ch. 639, *An Act to Codify MaineCare Rate System Reform,* codified in 22 M.R.S. Sec. 3173-J. The Department issued a Rate Determination Initiation Notice on September 27, 2022. The Department held a public rate forum on December 1, 2022, to collect stakeholder input and comments to inform the Rate Determination process for Medical Supplies and DME and accepted written comments through

December 15, 2022. The Department determined that for medical supplies and DME for which there is a Medicare rate, the Medicare rate represents the most appropriate benchmark, and payment of 100% of current year Medicare is appropriate. The Department also determined that the rates for medical supplies and equipment that are not covered by Medicare should receive an annual inflation adjustment based on the Consumer Price Index for All Urban Consumers for medical equipment and supplies (CUUR0000SEMG). The Department complies with 22 M.R.S. Sec. 3173(3), by engaging in APA rulemaking to implement this amended reimbursement methodology. The expansion of the current Medicare reimbursement methodology, adding the COLA adjustment to the calculation of the costs of other state Medicaid agencies for non-Medicare DME, and rental period changes are applied retroactive to January 1, 2023, as the changes, consistent with 22 MRS 42(8), benefit DME providers.

- Deletes most of Appendix I. Appendix I contains specific PA criteria for select items. The Department is moving most of these criteria to the MaineCare Health PAS Portal (https://mainecare.maine.gov/Default.aspx). The rulemaking removes references to Appendix I and refers providers to the Portal. The Department is proposing this change for purposes of efficiency and flexibility, as it will no longer utilize APA rulemaking to make changes to certain medical criteria/standards. Some medical criteria will remain in the APA rule: Appendix I, Section 60.12(L), Orthotics and Prosthetics, moves to new Section 60.08-2, Orthotics and Prosthetics; and Appendix I, Section 60.12(Z), Specially Modified Foods and Formulas, moves to Section 60.08-4, Specially Modified Foods and Formulas.

As described in the List of Changes to the Final Rule at the end of the Summary of Comments and Responses document, the Department made the following changes in the adopted rule (compared to the changes that were included in the proposed rule):

1. In response to a comment, the Department added language that clarifies members are responsible for paying required co-payments in Section 60.10-10

2. In response to a comment, the Department corrected incorrect headers that appeared after Section 60.07.

3. In response to a comment, the Department added breast milk storage bags and CPAP and Bi-PAP supplies to the list of items that can be dispensed in 90-day supplies in Section 60.08-13.

4. As a result of final rule review, the Department removed “Power Operated Vehicles” from the title of Section 60.08-8 because “Power Mobility Devices” is inclusive of power operated vehicles.

5. Pursuant to P.L. 2023, ch. 216, as codified in 22 MRS 3174-KKK, the Department specified in Section 60.08-16 that electric breast pumps and supplies are covered under MaineCare without prior authorization or limitation when they are prescribed by a Qualified Provider. This provision in policy will be effective on October 25, 2023, the date the law becomes effective. Note that the Department already covers electric breast pumps and supplies without prior authorization or limitation.

6. As a result of final rule review, the Department removed “The Department shall submit to CMS and anticipates approval for a State Plan Amendment related to these provisions” from Section 60.10 because Centers for Medicare & Medicaid Services (CMS) approved the relevant state plan amendment.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare website at http://www.maine.gov/dhhs/oms/rules/index.shtml or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or Maine Relay number 711.

A concise summary of the adopted rule is provided in the Notice of Agency Rulemaking Adoption, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process. Please address all comments to the agency contact person identified in the Notice of Agency Rulemaking Adoption.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Chapter II, Section 60, Medical Supplies and Durable Medical Equipment

ADOPTED RULE NUMBER:

CONCISE SUMMARY:

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See http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.

EFFECTIVE DATE: October 31, 2023

STATUTORY AUTHORITY: 22 M.R.S. §§ 42, 42(8); 3173; 22 M.R.S. 3173-J; 42 CFR § 440.70; P.L. 2021, ch. 398, Sec. A-17; P.L. 2023, ch. 216, codified in 22 M.R.S. Sec. 3174-KKK

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SECTION 60 **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT** Established: 06/01/85 Last Updated: 10/31/2023

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SECTION 60	**MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**	Established: 06/01/85 Last Updated: 10/31/2023

60.01 DEFINITIONS

60.01-1 **Activities of Daily Living (ADL)** are those activities related to personal care including but not limited to: showering, bowel/bladder management, eating, functional mobility, personal device care (hearing aids, etc.), personal hygiene, and toileting.

60.01-2 **Adjusted Acquisition Cost** is the lowest price paid to a supplier by an eligible provider for Durable Medical Equipment or medical/surgical supplies after adjustments for quantity discounts, any prompt payment discounts and excluding all associated costs, including but not limited to, shipping, freight, handling, and insurance costs. Wheelchair providers need not adjust the price paid to a supplier based on any prompt payment discount.

60.01-3 **Department** is the Maine Department of Health and Human Services.

60.01-4 **Durable Medical Equipment (DME)** is:

A. Equipment that can withstand repeated use;

B. Primarily used to serve a medical purpose and is medically necessary and reasonable for the treatment of the member's disability, illness, or injury or to improve an altered body function. Examples of items that are not primarily used for medical purposes include air conditioners, pools, exercise equipment, and equipment primarily used for the convenience of a caregiver;

C. Not generally useful to a person in the absence of disability, illness, or injury; and

D. Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place and is in safe and reasonably good condition and suitable for its intended use.

All four (4) of the above criteria must be met for coverage under this Section. Specific definitions and criteria are located on the MaineCare Health PAS Online Portal.

Home/Environmental modifications do not meet the definition of medical supplies or DME and are not covered under this Section.

60.01-5 **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)** is a facility that meets State licensing and Federal certification requirements for ICFs-IID.

60.01-6 **Medical Supplies** are those Medical Supplies that are primarily needed to relieve or control a medical condition. Examples of supplies not primarily needed to relieve or

60.01 **DEFINITIONS** (cont.)

control a medical condition include, but are not limited to, room and underarm deodorants.

60.01-7 **Nursing Facility** (NF) means a Skilled Nursing Facility (SNF) in the Medicare program or a Nursing Facility (NF) in the MaineCare program which meets State licensing and Federal certification requirements for nursing facilities and has a valid agreement with the Department of Health and Human Services.

60.01-8 **Prior Authorization (PA)** is the process of obtaining prior approval as to the medical necessity and eligibility for a service.

60.01-9 **Power Mobility Device (PMD)** includes both integral frame and modular construction type Power Wheelchairs (PWCs) and power operated vehicles (POVs).

60.01-10 **Power Operated Vehicle (POV)** is a chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and three or four-wheel non-highway construction.

60.01-11 **Power Wheelchair (PWC)** is a chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated or modular seating system, electronic steering, and four or more wheel non-highway construction.

60.01-12 **Qualified Provider** is a provider who is qualified by education, training, and licensure/regulation to perform services within his or her scope of practice.

60.02 **ELIGIBILITY FOR CARE**

Individuals must meet the eligibility criteria as set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

60.03 **DURATION OF CARE**

Each Title XIX and XXI member is eligible for as many covered services as are medically necessary and subject to limitations within this Section. The Department reserves the right to request additional information to determine medical necessity or expected therapeutic benefit of prescribed supplies or equipment.

60.04 **PROVIDER REQUIREMENTS**

Providers of Medical Supplies and DME are enrolled MaineCare providers that:

A. Have executed a MaineCare Provider Agreement with the Department of Health and Human Services and have obtained a provider identification number from the Department;

60.04 **PROVIDER REQUIREMENTS** (cont.)

B. Provide Medical Supplies and/or DME services to MaineCare members; and

C. Have a storefront located in Maine or within fifteen (15) miles of the Maine border in New Hampshire with a commercial address for the sales and service of the supplies and equipment sold, rented, or otherwise provided to members and regularly staffed operating hours. Providers must post hours of operation in a visible location for the general public and not be solely a sales representative for a manufacturer of DME or Medical Supplies.

D. **Hearing Aids only**: In addition to the requirements above, hearing aids, accessories, and repairs must be provided by an individual licensed by the State of Maine as an audiologist or as a licensed hearing aid dealer & fitter.

The following exceptions apply:

1. DME and supplies provided to a member who is residing out of state, only for the purposes of meeting an emergency medical need, with PA, at the discretion of the Department, taking into account cost effectiveness and medical necessity and only if the item(s) cannot be supplied by a MaineCare enrolled provider;

2. A provider who is the sole provider of a type of cost-effective, medically necessary DME may be enrolled only for the purpose of providing that item with PA. The provider must warranty the item for parts and labor.

3. The Department reserves the right to issue a request for proposals for provision of any supply or piece of equipment, and the resulting contract may be awarded to an out-of-state provider. The Department may enter into a special purchasing arrangement with one or more vendors capable of providing services to MaineCare members without the vendor having a physical storefront.

4. The Department may waive the requirement for providers to have a storefront in Maine or within fifteen (15) miles of the border if the Department, in its sole discretion, determines that waiving that requirement is in the best interests of the MaineCare program.

5. The Department will waive the requirement to have a storefront in Maine or within fifteen (15) miles of the border for audiologists operating outpatient services that are not enrolled as a DME provider and manufacturers of specialty modified low protein foods and formulas for the purpose of billing the Department as the supplier of prescription metabolic foods.

60.05 **COVERED SERVICES**

A covered service is a service or item for which payment can be made by the Department, and which meets the definitions listed in Section 60.01 and any other criteria or limitations described in this Section.

60.06 POLICIES AND PROCEDURES

60.06-1 Face-to-Face Encounter

A face-to-face encounter is a mandatory encounter (including encounters through telehealth (as described in Chapter I, Section 4) and other than encounters incidental to services involved) between the member and a Qualified Provider that takes place within the six (6) months prior to the date of a written order for DME. The written order may be, but does not have to be, prescribed by the provider who performed the face-to-face encounter.

60.06-2 Medical Supplies and DME Requirements

Medical Supplies and DME must meet all of the following requirements:

A. Comply with the criteria in Section 60, including the definitions in Section 60.01;

B. Be prescribed by a Qualified Provider;

C. Be provided to a member who is not in a hospital, unless necessary for transition to home, in which case the provider must comply with the criteria for emergency rental in this Section;

D. Have scientifically valid clinical evidence of their efficacy and not be considered investigational or experimental by the Department;

E. Be approved and defined by the Food and Drug Administration;

F. Be cost-effective;

G. Have a warranty that includes parts and labor;

H. Be provided by a MaineCare authorized provider of Medical Supplies and DME who has a location where members can procure repairs and servicing of items with warranties and guarantees or meet one of the exceptions outlined in this Section; and

I. A member's need for medical supplies, equipment, and appliances must be reviewed by a physician or other Qualified Provider annually.

J. **Durable Medical Equipment Only**. The prescribing provider must maintain documentation that includes a statement verifying the date of the face-to-face encounter for that specific piece of DME and the name of the Qualified Provider who performed the face-to-face encounter.

60.06 **POLICIES AND PROCEDURES** (cont.)

60.06-3 **Reasonable and Necessary for Treatment**

All DME and supplies must be certified as reasonable and necessary by the prescribing provider. In making such a determination, the following criteria shall be met:

A. The equipment is medically necessary;

B. The equipment serves a different purpose than equipment already available to the member; and the equipment is not an upgrade for currently functioning equipment that meets members' basic needs and already supplied to the member;

C. The equipment is not more costly than a medically appropriate and realistically feasible alternative plan of care;

D. The cost of the item is not disproportionate to the therapeutic benefits which could ordinarily be derived from use of the equipment;

E. The item is not Home/Environmental modifications, which do not meet the definition of Medical Supplies or DME and are not covered under this Section; and

F. Providers must retain documentation, if applicable, indicating the equipment can freely pass through all entryways without the need for modification or, if applicable, retain documentation indicating that necessary modifications or structural changes have occurred prior to the request for authorization.

60.06-4 **Rental and/or Purchase**

The Department shall rent and/or purchase items consistent with Medicare practices. If Medicare makes an item available for both purchase and rental, the Department or its authorized entity shall decide between rental and purchase of the item on a case by case basis based on medical necessity.

A. **Rental**

1. All rental equipment except for emergency equipment must receive PA. Please refer to the PA section regarding emergency equipment. The request for continued PA of services must indicate the emergency dates of services.

2. The Department decides when to purchase rented equipment if a member requires its use for an extended period of time. If the Department decides to purchase the rented equipment, the total rental

60.06 **POLICIES AND PROCEDURES** (cont.)

paid to date will be applied to the MaineCare allowed purchase price as listed in the fee schedule or as otherwise set by the Department.

3. Unless otherwise authorized under this section, rental rates include the cost of servicing, repairs or other maintenance and include replacement parts for defective equipment and disposable items. The Department is not responsible for the cost of repairs (including labor or replacement parts) for rented items or equipment.

4. All rented equipment must be clean and in proper working condition when delivered.

B. **Outright Purchase of New DME**

1. The Department may purchase outright any DME if the member will use it for an extended period of time. Once an item is purchased, it becomes the property of the member.

2. The Department reserves the right to purchase the necessary equipment at the lowest price available and to preferentially choose equipment that includes a warranty.

3. All purchased equipment must be new and unused, clean, in proper working condition, free from defects, and meet all implied and expressed warranties.

C. **Outright Purchase of Used Equipment**

Used equipment will be reimbursed on a prorated basis using the remaining useful life of the equipment based on Generally Accepted Accounting Principles (GAAP) applied to the MaineCare rate of reimbursement. To qualify for payment, a DME provider must complete a PA form(see Section 60.06). The equipment being reconditioned must not exceed the expense for new equipment.

D. **Delivery, Installation, and Member Instructional Time**

The maximum allowable fee for purchase or rental of equipment includes the following:

1. Cost of delivery to the inside of the member's residence and, when appropriate, to the room in which the equipment will be used;

60.06 **POLICIES AND PROCEDURES** (cont.)

2. Assembly of parts, installation, and set-up of the equipment or customized fitting;

3. Instruction to the member or caregivers in the safe and proper use of the equipment or supplies, sufficient to ensure that they have demonstrated they can provide necessary service and/or use of the equipment or supplies. Instructions to ensure safe and proper use of the equipment or supplies and any limitations on replacement.

60.06-5 **Emergency DME**

In an emergency, the Department will reimburse rental of standard DME for up to thirty (30) days, subject to the PA requirements in this Section.

If the Department decides to purchase the rented equipment, the total amount paid to date will be applied to the MaineCare allowed purchase price as listed in the fee schedule or as otherwise set by the Department.

60.06-6 **Labor**

Labor charges are reimbursable for repairs to outright purchased DME only. Such charges are not reimbursed when the DME has a current warranty. Labor charges are not reimbursed for evaluation, assembly, fitting, or other installation on both new and used purchased DME. The Department is not responsible for labor charges for rented DME. Labor is also subject to the PA requirements of this Section (see Section 60.06).

60.06-7 **Replacement of DME**

Replacement will not be allowed in cases of malicious damages, culpable neglect, or when the member or responsible party has sold, given away, thrown out, or wrongfully disposed of the DME. DME that is functioning properly will not be replaced, unless a change in the member's condition requires a change of DME.

A. **Replacement of all DME is allowed for the following reasons:**

1. Irreparable damage or wear that affects the essential performance of the DME;

2. A change in the member's condition that requires a change of DME. In such cases, the Department requires a current prescribing provider's order documenting the need for the change; or

60.06 **POLICIES AND PROCEDURES** (cont.)

3. Repairing the DME (parts and labor) would cost more than sixty (60) percent of the replacement cost of the DME.

B. **Additional Rules for Hearing Aids**

1. Members age twenty-one (21) years and older, in addition to the criteria above, are eligible to receive one (1) hearing aid or one (1) replacement pair every five (5) years. PA will be required and must meet the criteria specified in section 60.06-2.

2. Members under the age of twenty-one (21), are eligible to receive a replacement hearing aid once per year as medically necessary and as identified and referenced in the *MaineCare Benefits Manual*, Section 94.

C. **Additional Rules for Automatic Positive Airway Pressure (APAP) and Continuous Positive Airway Pressure (CPAP) Devices ≥ five (5) years old**

1. The DME supplier is required to perform an assessment on the device before the Department will consider replacement or repair;

2. If there is no obvious external reason as to why the device is no longer functioning properly, the DME supplier is required to submit a written attestation detailing this; OR

3. If the reason the device is not functioning is obvious, the DME supplier is required to submit documentation, including repair cost information, to the Department. Repair criteria can be viewed in section 60.06-2. Prior Authorization for repair is required and must meet the criteria specified in section 60.06-2.

D. **Additional Rules for Bilevel Positive Airway Pressure (Bi-PAP) Devices ≥ five (5) years old**

1. The DME supplier is required to perform an assessment on the device before the Department will consider replacement or repair;

2. If there is no obvious external reason as to why the device is no longer functioning properly, the DME supplier is required to send the device to the Manufacturer for assessment;

3. Once the assessment has been completed, the DME supplier is required to submit documentation, including repair cost information, to the Department. Repair criteria can be viewed in section 60.06-2. Prior

60.06 **POLICIES AND PROCEDURES** (cont.)

Authorization for repair is required and must meet the criteria specified in section 60.06-2.

60.06-8 **Requirements for Medical Supplies and DME for Members Residing in Their Home**

A. Covered Medical Supplies and DME may be provided to members for use in any setting in which normal life activities take place, other than a hospital or any setting in which payment is or could be made under MaineCare for inpatient services that include room and board. Special rules apply for Medical Supplies provided to members in Nursing Facilities (NF) and intermediate care facility for individuals with intellectual disabilities (ICF- IID).

B. Providers may not bill under this section for routine Medical Supplies essential for the home health agency to carry out the physician's plan of care for members receiving home health services (see Section 40 of the *MaineCare Benefits Manual*).

C. Post-surgical supplies will be covered as long as medically necessary as certified by the prescribing provider. Providers may not dispense more than a thirty-four (34) day supply at a time, with the exception of items specified in section 60.07-13.

D. Equipment or items that are used primarily for purposes of safety or physical restraint are not covered, including enclosed cribs and beds and barred enclosures. Physical restraints are defined as any physical or mechanical device, material, or equipment, attached or adjacent to the member's body that the member cannot remove easily and which restricts freedom of movement or normal access to one's body.

E. Items used for positioning that meet the definition of Medical Supplies or DME are not considered restraints and are covered when medically necessary.

60.06-9 **Medical Supplies and DME Not Covered for Members in an NF or ICF-IID**

The Department will not reimburse DME providers for Medical Supplies and DME, including upgrades and add-ons, provided to MaineCare members residing in a NF or ICF-IID that are considered part of that facility's regular rate of reimbursement. Some supplies and equipment provided to members in a NF or ICF-IID as part of the regular rate are listed below and are included for reference only.

Facilities that serve a special group of individuals with disabilities are expected to furnish that equipment which is normally used in their care (e.g. children's wheelchairs) as a part of their reasonable cost.

60.06 **POLICIES AND PROCEDURES** (cont.)

The following items may not be billed by either the facility or supplier.

1. Alcohol, swabs and rubbing
2. Analgesics, non-prescription: a) aspirin: plain buffered and coated suppositories. b) Acetaminophen: tablets, liquids, and suppositories.
3. Antacids, non-prescription: a) aluminium/magnésium hydroxyde (ex. Maalox) b) Aluminium/magnésium hydroxyde with simethicone (ex. Mylanta, Maalox Plus) c) Calcium carbonate tablets (ex. Tums) d) Calcium carbonate/ magnésium hydroxyde tablets (ex. Rolaids).
4. Alternating pressure pads, air mattresses, "egg crate" mattresses, gel mattresses
5. Applicators
6. Bandages
7. Band-Aids
8. Basins
9. Beds, standard hospital type, not therapy
10. Bed pans
11. Bed rails
12. Blood pressure equipment
13. Bottles, water
14. Canes
15. Calcium supplements, non-prescription (ex. Tums, Oscal).
16. Catheters
17. Catheter trays, disposable
18. Chairs, standard and geriatric
19. Commodes
20. Corner chair
21. Cotton
22. Cough syrup and expectorants, all non-prescription brands
23. Crutches
24. Cushions (e.g., comfort rings), excluding wheelchair cushions that require mounting hardware

25 Dietary supplements

26. Disinfectants
27. Douche trays, disposable
28. Dressings
29. Enema equipment
30. Enteral feeding, supplies, and equipment.
31. Facility deodorants
32. Gauze bandages, sterile or non-sterile
33. Glucometers
34. General service supplies such as administration of oxygen and related medications, hand feeding, incontinency care, tray service, and enemas
35. Gloves, sterile or non-sterile
36. Gowns

60.06 **POLICIES AND PROCEDURES** (cont.)

37. Ice bags
38. Incontinency supplies (full brief- all sizes; bed pad; undergarment liners, disposable or reusable; under pads)
39. Irrigation trays
40. Laundry services, personal (including supplies and equipment)
41. Laxatives, non-prescription: Stool softeners (ex. Docusate sodium liquid or capsule). Bulk: (ex. Psyllium). Stimulants: (ex. Bisacodyl tablets and suppositories; docusate casanthranol, liquid and/or capsule). Enemas: (ex. Saline, phosphate types-except Fleets); oil retention. Misc.: milk of magnesia; glycerin suppositories; lactulose and analogs (when used as a laxative); mineral oil.
42. Lubricants, skin, bath oil
43. Mats – ICF- IID only
44. Ointments and creams, available over the counter, including petroleum jelly and hydrocortisone 0.5%
45. Ophthalmic lubricants, tears and ointments
46. Oxygen, for emergency and prn use only, including portable oxygen and equipment
47. Parenteral supplies and equipment
48. Pillows
49. Pitchers, water
50. Powders, medicated and baby
51. Prone boards
52. Restraints, poseys, thoracic chest supports, wedge pillows, etc.
53. Sand and water tables – ICF- IID only
54. Sensory stimulation materials– ICF- IID only
55. Sheepskin pads, any size or style
56. Shower chairs
57. Soap, including hypoallergenic
58. Special dietary supplements
59. Specimen containers
60. Sterile I.V. or irrigation solution
61. Stethoscopes
62. Supplies, non-prescription, necessary for the treatment for decubitis
63. Suture sets
64. Swabs, medicated or unmedicated
65. Syringes and needles
66. Tapes
67. Testing materials to be used by staff of facility, not to include materials normally included in psychometric testing – ICF- IID only
68. Thermometers
69. Towels, washcloths
70. Tongue depressors
71. Traction equipment
72. Trapezes

60.06 **POLICIES AND PROCEDURES** (cont.)

73. Tub seats
74. Tubes, gavage, lavage, etc.
75. Under pads
76. Urinals
77. Urinary drainage equipment and supplies (disposable)
78. Velcro strips - ICF- IID only
79. Vestibular boards – ICF- IID only
80. Vitamins, non-prescription, all brands
81. Walkers
82. Wheelchairs, standard, including those with removable or adjustable trays, arm and leg rests including elevators, pediatric, "hemi" chairs, reclining wheelchairs, lightweight wheelchairs, high strength light-weight wheelchairs, ultra-light-weight wheelchairs, heavy duty wheelchairs, extra heavy-duty wheelchairs and other manual wheelchairs/base.
83. Wipes, rectal medicated
84. Routine personal hygiene and grooming items to include, but not be limited to items for shaving, shampooing, bathing, nail clipping (unless specified as a covered service when performed by a podiatrist as covered under the *MaineCare Benefits Manual*), haircutting or the services of a barber when requested and paid for by the member. Examples of items include but not limited to: combs, lotions, mouthwash, toothbrushes, toothpaste, shampoo (regular, medication and non-tears baby shampoo), sunscreen and tissues.

60.07 **PRIOR AUTHORIZATION REQUIREMENTS**

Some Medical Supplies and DME require PA for MaineCare to provide payment. The Department or its authorized entity processes PA requests. More information on the PA process is in *MaineCare Benefits Manual*, Chapter I, Section 1. The MaineCare Health PAS Online Portal contains a complete list of Medical Supplies and DME that require PA and corresponding PA criteria sheets. Providers should research each item on the MaineCare website to assure it is covered and check whether it requires PA at https://mainecare.maine.gov/Default.aspx, which includes a link to the PA portal. The Department reserves the right to require an evaluation by appropriate clinical professionals of its choice before granting PA.

In cases where the member does not meet the PA criteria, the provider or member may submit additional supporting evidence, such as medical documentation, to demonstrate that the requested service is medically necessary.

Providers shall make requests for PA on the Department’s approved form and get approval prior to the date of service.

60.07 **PRIOR AUTHORIZATION REQUIREMENTS** (cont.)

Proper documentation includes proof of acquisition cost or a price quote from a manufacturer. If a claim is not equal to the exact amount of the PA, a subsequent adjustment to the authorization may be made with appropriate documentation. Claims should not be submitted until the adjustment is made. Alternatively, the Department may choose to issue a letter approving the request for PA without assigning an approved amount.

Once documentation of Adjusted Acquisition Cost (AAC) is received from the provider, MaineCare staff will assign an allowable amount. A completed Medicare Certificate of Medical Necessity (CMN) shall include itemized AAC and usual and customary charges for the equipment.

The Department reserves the right to request detailed documentation, including material and labor costs and total hours for the manufacture or fabrication of orthotic and prosthetic devices. This information may be estimated prior to the manufacture or fabrication. However, actual costs must be submitted upon completion. Non-compliance may result in denial of payment or recoupment of payments.

The Department will not refuse to prior authorize a DME item based solely on a diagnosis, type of illness, or condition.

60.07-1 **General Categories and Conditions that Require Prior Authorization**

In addition to the specific items that require PA, the Department also requires PA for the following:

A. **Items with Cost Exceeding $699.00**

PA is required for any Medical Supplies and DME that costs MaineCare more than $699.00. The item must be prescribed by a Qualified Provider and be the most cost-effective item available that meets the medical needs of the member.

The cost of an item equals the total cost of all the item’s constituent pieces. For example, the cost of a wheelchair is the sum of the cost of each of its components including, but not limited to, foot plates, wheels, wheel rims, armrests, arm troughs, etc. Should the need arise for an unanticipated component, that item must have PA, regardless of price.

B. **Rental equipment**

Rental equipment requires PA, except in emergency situations. Oxygen is considered a rental.

60.07 **PRIOR AUTHORIZATION REQUIREMENTS** (cont.)

In an emergency, the Department does not require PA to rent standard equipment for up to thirty (30) days. The Department will pay the rental for this emergency period. In this section, the Department defines emergency as a situation where the member would not otherwise be able to return home from a hospital, rehabilitation facility, or nursing home, or when a prescribing provider determines a member must have the equipment within twenty-four (24) hours.

The provider must request PA authorization within thirty (30) days of providing the equipment if it is necessary to continue the rental beyond thirty (30) days. The Department will deny reimbursement beyond the thirty (30) day emergency period if the provider does not make this request. The Department will decide, within thirty (30) days of the date the PA is requested, whether to approve, defer, or deny authorization for the rental beyond the thirty (30) day emergency period.

C. **Miscellaneous DME**

Miscellaneous DME, including those billed under the Healthcare Common Procedure Coding System (HCPCS) code E1399 or any other DME billed under another code which contains the phrase “miscellaneous,” “accessories,” "not otherwise specified," or "not otherwise classified" in its description when the MaineCare allowed amount exceeds $99.99, requires PA.

D. **DME Parts**

DME parts for member-owned DME previously supplied and covered under MaineCare require PA. For example, a part related to a wheelchair that previously required PA would also require PA. DME parts that fall under warranty will not be covered.

The Department is not responsible for the cost of parts for rented DME.

E. **Repairs to DME**

Repairs to member-owned DME with a total cost (parts and labor) exceeding sixty percent (60%) of replacement cost require PA, at which time the Department will decide if replacement of the DME is appropriate.

PA is required for any repair if replacement parts, labor, or the combination are over $699.00 to repair medically necessary DME. The Department reserves the right to request documentation necessary to validate medical necessity before PA is granted.

60.07 **PRIOR AUTHORIZATION REQUIREMENTS** (cont.)

Reimbursement is not allowed for repair of any DME that is still under warranty.

The Department is not responsible for the costs associated with repairs to rented DME.

F. **Outright Purchase of Used Equipment**

To qualify for PA, information on the Department's approved PA form or the appropriate CMN must indicate that the same warranty is offered on used equipment as on new equipment. The equipment being reconditioned shall not exceed the expense for new equipment.

G. **Other Items Subject to Coverage Limitation**

Some items subject to coverage limitations may be covered in excess of the limitation under limited circumstances when prior authorized by the Department. These items can include power operated vehicles and wheelchairs, hospital beds, standard mattresses for hospital beds, prosthetic devices to allow functional mobility, nebulizers, respiratory suction pumps, and CPAP and Bi-Pap devices and supplies.

60.07-2 **Exceptions to Prior Authorization Requirements**

The following exceptions apply to MaineCare PA requirements:

A. A member has received PA to reside out of state due to an emergency medical need, is living out-of-state and now requires medically necessary DME or supplies which cannot be supplied by a MaineCare enrolled provider.

B. PA for Hearing Aids and accessories are not required for members under the age of twenty-one (21) except for miscellaneous procedure codes which do require PA.

60.08 **RESTRICTED SERVICES**

This section describes coverage restrictions and limitations for Medical Supplies and DME. Changes in technology alone do not necessitate replacement or upgrades in equipment. If it is medically necessary for a member to exceed any of the listed limits, the prescribing provider must submit a request for PA and provide supporting medical documentation to establish the medical necessity. Unless otherwise specified, limits apply to all members twenty-one (21) years and older.

60.08 **RESTRICTED SERVICES** (cont.)

60.08-1 **Physician Provided Supplies**

Physicians may bill for those medical supplies needed to perform office procedures, which are above and beyond what is usually included in a normal office visit. Reimbursement is made on the basis of acquisition cost only and may not include any additional markup. Physicians must bill under Chapter II, Section 90, "Physician Services" of the *MaineCare Benefits Manual*.

A prescribing provider may not be reimbursed for both prescribing and supplying DME to the same member, unless the DME is otherwise unobtainable or the DME typically requires no maintenance or replacement during the period used by a member. If these circumstances do exist, reimbursement to the prescribing provider for also supplying DME shall be on the basis of the acquisition cost of the DME. The prescribing provider must maintain a copy of the invoice to support such claims. In addition, this policy shall also apply to any entity in which the provider has direct or indirect proprietary interest. All transactions are subject to State and Federal restrictions regarding self-referral.

DME providers may not bill for items delivered to a member in a prescribing provider's office.

60.08-2 **Orthotics and Prosthetics**

The Department requires that orthotic or prosthetic services be provided by a licensed occupational therapist, a licensed physical therapist, prosthetist (American Board for Certification), or an accredited orthotist (Board for Orthotist Certification). PA is required for all custom molded orthotics and prosthetics regardless of price using evidence-based criteria and/or criteria based on national standards for evaluating what is considered medically necessary.

Providers shall warranty prosthetics for a period of one (1) year to assure proper fit of products purchased by the Department. The warranty will cover adjustments, repairs, and parts replacement associated with shrinkage, workmanship, etc.

60.08-3 **Augmentative and Alternative Communication Devices**

Members must trial augmentative and alternative communication devices before the Department will purchase or rent the devices. PA requests for augmentative and alternative communication devices shall include information documenting the trial period to determine the appropriateness and member utilization of the device.

60.08-4 **Specially Modified Foods and Formulas**

Specially modified foods and formulas are covered when the member has inborn errors of metabolism.

60.08 **RESTRICTED SERVICES** (cont.)

60.08-5 **Orthopedic Shoes and Other Supportive Devices for Feet**

Orthopedic shoes and other supportive devices for the feet generally are not covered. However, shoes that are an integral part of a leg brace, and therapeutic shoes such as those furnished to diabetics, are covered. For members twenty-one (21) and older, these items are subject to the following limitations:

A. Items classified with HCPCS Level II codes as foot inserts, foot arch supports, shoe wedges or shoe heels are limited to two (2) units (meaning 2 items or 1 pair) per member per year.

B. Items classified with HCPCS Level II codes as orthotic footwear, including orthopedic shoes or items classified as 'other orthopedic footwear', are limited to two (2) units (meaning 2 shoes or 1 pair) per year.

C. Items classified with HCPCS Level II codes as shoe lifts are limited to eight (8) units per member per year (units are one (1) inch increments).

D. Items classified with HCPCS Level II codes as diabetic footwear including diabetic shoes and fittings are limited to two (2) units per member per year (meaning 1 pair or 2 fittings). Modifications and inserts for diabetic shoes are limited to a combined total of six (6) units per member per rolling year.

E. Items classified with HCPCS Level II codes as repositioning foot orthotics, excluding the words "abduction rotation bar" are limited to two (2) units (meaning 2 shoes or 1 pair) per year.

60.08-6 **Nebulizers**

Nebulizers are limited to one per member every five (5) years for members twenty-one (21) and older.

60.08-7 **Incontinence Supplies**

A. The monthly service limits for diapers and other disposable incontinence products for members twenty-one (21) years and older are as follows:

1. Disposable briefs or pull ons are limited to eight (8) units per day for adults.

2. Disposable personal pads, large sized disposable under pads, liners, shields, guards, and undergarments are limited to one hundred and fifty (150) units per thirty-six (36) day period for adults.

60.08 **RESTRICTED SERVICES** (cont.)

3. Disposable non-sterile gloves are limited to 5 boxes (at 100 per box) or 500 gloves per member per 36-day period for adults. Effective January 1, 2019, gloves may be covered if the member requires a caregiver to change the briefs/pull-ups; this will require documentation by the prescribing provider in the member's medical record. If the member is able to change his/her own briefs/pull-ups, then gloves shall not be covered unless there is a specific medical need for gloves documented by the prescribing provider in the member's medical record.

B. Incontinence supplies are not covered for children under five (5) years of age. If it is medically necessary for a child age four (4) years and younger to use incontinent supplies, then a DME provider may submit a request for PA which must include sufficient supporting medical documentation from the prescribing provider (i.e., specific medical exam records and supporting medical literature that shows that the member's medical condition causes incontinence that would not otherwise be normally expected in this age group) to establish the medical necessity and a bowel/bladder training program has failed. The request will be reviewed and decided by the Department or its Authorized Entity.

C. Providers may provide up to a ninety (90) day supply. Members may refuse to accept more than a thirty-six (36) day supply.

60.08-8 **Power Mobility Devices and Manual Wheelchairs**

Reimbursement for Power Mobility Devices (PMDs) requires PA whether or not the member is eligible for Medicare or other third party insurance. The PA criteria for PMDs are located on the MaineCare Health PAS Online Portal.

In the case of motorized wheelchair requests for Medicare/MaineCare dually eligible members, MaineCare will review the request and issue a PA decision and the allowable reimbursement rate if approved. The decision must be issued prior to the purchase of any Power Wheelchair (PWC) or Power Operated Vehicle (POV), and prior to the submission of any claims to Medicare. Any price changes for PWCs and POVs that have received Prior Authorization shall be treated in the same manner as all other price changes on prior authorized equipment.

A. **Limitations**

The following limits apply to members twenty-one (21) years and older. Providers may submit documentation detailing the need to exceed the limits, and the Prior Authorization Unit will evaluate the need to exceed the limit.

60.08 **RESTRICTED SERVICES** (cont.)

1. **Power Operated Vehicles**: Members will be limited to one (1) Power Operated Vehicle (i.e. scooter) every three (3) years, and cannot upgrade to a power wheelchair until the three (3) years have lapsed.

2. **Manual or Power Wheelchairs**: Members will be limited to one (1) wheelchair (i.e. manual or Power Wheelchair) every five (5) years.

B. **General Requirements**

1. **Manual or Power Wheelchairs**: Members who meet the eligibility requirements for both a prosthetic device necessary to allow functional mobility and a power or manual wheelchair must choose between the prosthetic device and a wheelchair and must sign a letter exercising their choice. A wheelchair will be provided in the interim on a rental basis for those members choosing a prosthetic device. Members may seek a PA for a manual wheelchair in addition to a prosthesis if medically necessary.

2. Regardless of the type, only one wheelchair at a time is reimbursable for each member.

3. The primary purpose is not to allow the member to perform leisure or recreational activities.

4. Reimbursement is allowed for amputee kits for standard wheelchairs in a NF or ICF- IID. Reimbursement for a wheelchair with right or left-handed drive is allowed in case of arm amputee or paralysis.

5. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

6. An exception to the requirement in Section 60.06-3(F) may be granted for a member who needs a wheelchair during the winter months but is unable to make the necessary home modifications due to the frozen conditions. The provider may not bill the Department for modifications or structural changes, as they are not a MaineCare-covered DME service.

7. If a member-owned PMD meets coverage criteria, medically necessary replacement items, including but not limited to batteries, are covered.

60.08 **RESTRICTED SERVICES** (cont.)

8. MaineCare does not consider inability to climb stairs a medically necessary indication for a PMD. A PMD is not considered medically necessary when the sole purpose is to elevate a person to eye level, to extend a wheelchair user's reach. In addition, inability to navigate rough terrain outside the home is not considered a medically necessary indication for a PMD.

9. When requesting a PA for a PMD in a NF or other setting in which there is continuous supervision, the requesting provider must document the member's medical necessity to be independently mobile beyond what can be provided by staff in that setting.

10. The Department will not approve equipment for purposes other than medical necessity.

C. **Evaluation and Documentation Requirements**

The following evaluation and documentation requirements must be met for the Department to approve PMDs:

1. The prescribing provider must perform a face-to-face evaluation with the member and shall refer the member to an experienced, licensed, MaineCare enrolled physical therapist (PT), occupational therapist (OT), or other provider who has specific training and experience in rehabilitation wheelchair evaluations. The prescribing provider shall provide medical documentation of the medical disease, syndrome, and/or functional impairment(s) that justify the medical necessity for the equipment and accessories;

2. The PT/OT shall conduct an evaluation and provide a signed and dated report that includes equipment recommendations and identifies the medical disease, syndrome, and functional impairment(s) that justify the medical necessity for the equipment and accessories. The PT/OT shall have no financial affiliation with the medical equipment supplier. Accessories will be approved or denied based on MaineCare Criteria, as normal;

3. The DME provider is required to retain the above documentation and a completed and signed home access report. The documentation should also include a statement indicating the member is able to transfer safely in and out of the PMD and has adequate trunk stability to safely ride in the PMD;

60.08 **RESTRICTED SERVICES** (cont.)

4. The DME provider shall obtain a written prescription for the PMD, signed and dated by the prescribing provider who performed the face-to-face evaluation, within 45 days of the evaluation;

5. The DME provider shall provide documentation to the Department, signed by the member, indicating that the member has been informed that the member will be limited to one (1) POV every three (3) years and cannot upgrade to a Power Wheelchair until the three (3) years have lapsed;

6. The DME provider shall provide the Department an itemized list of all the medically necessary items and their cost, as well as the provider's usual and customary prices for the items;

7. Documentation of the member's current height and weight are included in the member's medical record; and

8. The member must have a letter from his or her physician stating that the member's condition is not expected to deteriorate significantly for three (3) years.

60.08-9 **Hospital Beds**

The following limits apply to members twenty-one (21) years and older:

A. Reimbursement will be limited to one (1) hospital bed every five (5) years.

B. Reimbursement will be limited to one (1) standard mattress (to fit a hospital bed) every two (2) years.

C. Trapeze bars attached to bed will be limited to two (2) per lifetime.

D. Cushioned headrest will be limited to one (1) per year.

60.08-10 **Other Limitations for Members Twenty-one (21) years of Age and Older**

A. Mattress Pads to include Gel and Dry are limited to one (1) per year.
B. Sitz bath is limited to one (1) per year.
C. Canes are limited to one (1) per year.
D. All walkers are limited to one (1) per year.
E. All commodes are limited to two (2) per five (5) year period.

60.08 **RESTRICTED SERVICES** (cont.)

F. Bath/shower chairs are limited to one (1) per five (5) year period.
G. Bath/tub wall rail is limited to two (2) per three (3) year period.
H. Raised toilet seat is limited to two (2) per three (3) year period.
I. Cough stimulating device is limited to two (2) per year.
J. All types of Intermittent Positive Pressure Breathing (IPPB) devices are limited to once per lifetime.
K. Ultrasonic and Aerosol compressors with Small Volume Nebulizers (SVNEB) are limited to one (1) per year.
L. Patient lift sling or seat is limited to one (1) per year.
M. Hydraulic patient lift is limited to two (2) per lifetime.
N. Transcutaneous Electrical Nerve Stimulator (TENS) units/treatment systems are limited to one (1) per year.
O. Pneumonic Compression Devices (used to lymphedema and chronic venous insufficiency) are limited to one (1) device per year.
P. Apnea monitors are limited to one (1) per year.
Q. Respiratory suction pumps (home model, portable or stationary, electric), when purchased, are limited to one (1) per member every three (3) years; if paid for on a rental basis, the physician must document therapeutic benefit for renewal after ninety (90) days.

60.08-11 **Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (Bi-PAP) Devices**

The Department requires sleep studies done within the three (3) years preceding the initial request to document the need for a CPAP and Bi-PAP device. All CPAP and Bi-PAP devices will be rented on a three- (3) month trial basis to determine appropriateness and member utilization. CPAP and Bi-PAP devices and supplies are limited to the following quantities for members under twenty-one (21):

A. Oral/nasal mask – one (1) per three (3) months
B. Oral cushion – two (2) per one (1) month
C. Nasal pillow – two (2) per one (1) month
D. Full face mask – one (1) per three (3) months
E. Facemask interface – one (1) per one (1) month
F. Nasal interface – two (2) per one (1) month
G. Head gear – one (1) per six (6) months
H. Chin strap – one (1) per six (6) months
I. Tubing – one (1) per one (1) month
J. Tubing (with heating element) – one (1) per three (3) months
K. Filter (disposable) – two (2) per one (1) month
L. Filter (non-disposable) – one (1) per six (6) months
M. Oral interface – one (1) per three (3) months
N. Exhalation port – one (1) per twelve (12) months
O. Water chamber – one (1) per one (1) month

60.08 **RESTRICTED SERVICES** (cont.)

P. Humidifier – one (1) per five (5) years
Q. C-PAP – one (1) per five (5) years
R. Bi-PAP – one (1) per five (5) years

60.08-12 **Hearing Aids**

Hearing aids shall be purchased from a licensed audiologist or hearing aid dealer & fitter, utilizing a vendor contracted with the State of Maine's Division of Procurement Services. For more information, please visit the Division of Procurement Service's hearing aids contracts webpage. Members shall trial hearing aids for a trial period of at least thirty (30) days. Following the trial period, the audiologist or hearing aid dealer & fitter will provide written confirmation that the hearing aid meets the member's need and should be purchased.

A. Hearing aid accessories are not required to be purchased under contract.

B. Hearing aids are subject to the following limitations:

1. Members twenty-one (21) years and older are limited to one (1) hearing aid or one (1) replacement pair every five (5) years.

2. For members under the age of twenty-one (21), replacements are allowed once per year as medically necessary and as identified and referenced in the *MaineCare Benefits Manual*, Section 94.05-2.

C. Six (6) replacement batteries are allowed per month.

D. Back up or spare hearing aids and/or repairs to backup or spare hearing aids are not covered.

60.08-13 **Dispense of Disposable Medical Supplies**

The Department shall authorize dispense of up to a ninety (90) day supply of items considered to be disposable medical supplies when medically necessary and all prior authorization approval has been obtained. The Department considers disposable medical supplies to include breast milk bags and incontinence, urological, ostomy, diabetic, and CPAP and Bi-PAP supplies.

60.08-14 **Breast Milk Bags**

Breast Milk Bags are limited to 120 units (bags) per member per rolling month.

60.08 **RESTRICTED SERVICES** (cont.)

60.08-15 **Automatic Blood Pressure Monitors**

Automatic Blood Pressure Monitors are limited to one unit per member per three (3) calendar years.

60.08-16 **Electric Breast Pumps and Supplies**

Effective October 25, 2023, in accordance with 22 MRS 3174-KKK, electric breast pumps and supplies are covered without prior authorization or limitation when they are prescribed by a Qualified Provider.

60.09 PROGRAM INTEGRITY

Program Integrity requirements are outlined in Chapter I of the *MaineCare Benefits Manual*.

60.10 REIMBURSEMENT

60.10-1 **General Reimbursement Methodology**

Effective January 1, 2023, reimbursement for medical supplies and DME will be the lowest of the following, unless otherwise specified in this section:

A. The maximum MaineCare allowed amount, which the Department will establish based on:

1. 100% of the current Medicare DMEPOS Fee Schedule amount; or

2. If no Medicare fee schedule amount is established, the average cost of the relevant services/codes from other state Medicaid agencies. These allowed amounts will receive an inflation adjustment on January first of each year based on the Consumer Price Index for All Urban Consumers for medical equipment and supplies (CUUR0000SEMG); or

B. The provider's usual and customary charge.

60.10-2 **Reimbursement for Incontinence Supplies**

Incontinence supplies are reimbursed based on invoice cost (excluding shipping) plus 40% (forty percent), not to exceed the maximum amount allowed on the MaineCare fee schedule published on the Department’s website.

60.10 REIMBURSEMENT (cont.)

Effective January 1, 2023, these allowed amounts will receive an inflation adjustment on January first of each year based on the Consumer Price Index for All Urban Consumers for medical equipment and supplies (CUUR0000SEMG). To request alternative incontinence supplies that are not on the MaineCare fee schedule, the provider must do the following for the request to be considered:

A. The provider must submit the billing code, brand name, and the cost of the requested item.

B. The provider must show that the member has trialed and failed at least three alternatives that are available at the set allowable amount or document the medical reason why they should not be or were not trialed.

C. The provider must document that the requested item is a cost-effective alternative to possible side-effects of current items available at the allowable amounts. For example, a member may need higher absorbency rate items due to skin break down or other adverse side-effects that occur with current supplies available at allowable amount.

If the item(s) are deemed medically necessary and a cost-effective alternative based on the above criteria, the reimbursement is not to exceed cost plus 40%.

60.10-3 **Contract with the Department for DME/Medical Supplies**

Where the Department has entered into a contract (separate from the MaineCare Provider Agreement) with a manufacturer or provider for the provision of DME/Medical Supplies, the following shall apply:

A. If the manufacturer/provider serves as a supplier only and does not provide direct services to MaineCare members, the manufacturer/provider shall bill the MaineCare provider who purchases the DME/Medical Supplies, in accordance with normal business practices, and at a price that is contained in the contract with the Department.

B. After the MaineCare provider who purchases the DME/Medical Supplies has paid the manufacturer/provider, the MaineCare provider can then bill MaineCare following the billing instructions outlined in this Section.

The Department will provide advance written notice to all providers that are required to purchase certain DME items from such manufacturers/providers.

60.10 REIMBURSEMENT (cont.)

60.10-4 **Reimbursement for DME/Medical supplies considered to be "miscellaneous DME/Medical Supplies"**

"Miscellaneous DME/Medical Supplies" means those DME/Medical Supplies billed under the Healthcare Common Procedure Coding System (HCPCS) code E1399 or any other DME/Medical Supplies billed under another code, which contains the phrase "miscellaneous," "accessories," "not otherwise specified" or "not otherwise classified" in its description. Miscellaneous codes can be used only if there has not been a nationally accepted code assigned to a product/service. Please reference the Healthcare Common Procedure Coding System (HCPCS) guide to identify whether a specific item has been assigned a nationally accepted code before billing the item as Miscellaneous. Miscellaneous DME/Medical Supplies will be reimbursed as follows:

A. If there is a Manufacturers' Suggested Retail Price (MSRP) the reimbursement will be MSRP minus twenty percent (20%). Documentation must be submitted supporting the MSRP.

B. If there is no listed MSRP, reimbursement will be invoice cost plus thirty percent (30%). Providers will need to submit an invoice for payment.

60.10-5 Specialty modified low protein food reimbursement will be invoice cost plus fifteen percent (15%). Providers must include invoice at the time of claims submission.

60.10-6 The Department shall reimburse rental items at the monthly rate published on the Department's website for a period not to exceed the rental period. Effective January 1, 2023, except for oxygen, rental periods shall follow Medicare rental periods:

A. Capped rental items (category code: CR) shall have a 13-month rental period;

B. Inexpensive and routinely purchased items (category code: IN) shall have a ten-month rental period;

C. Enteral and parenteral items (category code: EP) shall have a 15-month rental period; and

D. Items requiring frequent and substantial servicing (category code: FS) shall be rented until no longer medically necessary.

E. DME covered by the Department that is not covered by Medicare (category code: MC) shall have a 12-month rental period.

60.10 REIMBURSEMENT (cont.)

60.10-7 Oxygen (category code: OX) shall be rented for as long as it is medically necessary. Providers may bill for the appropriate oxygen equipment codes that include oxygen contents for as long as it is medically necessary. Providers do not need to bill for "content only" oxygen codes after thirty-six (36) months of renting oxygen equipment, as is required by Medicare. Oxygen requires annual PA.

60.10-8 Any manufacturer's rebate shall be paid to the Treasurer, State of Maine. Providers shall forward or otherwise pay to the Treasurer of the State of Maine all manufacturers' rebates associated with Durable Medical Equipment or Medical Supplies provided to members pursuant to this Section of the *MaineCare Benefits Manual*.

60.10-9 In accordance with Chapter I of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek payment from any other resource that is available for payment of a rendered service prior to billing the MaineCare Program.

Special provisions apply for Power Mobility Devices (PMD):

A. Prior to the provision of a PMD, providers must submit a request for reimbursement to MaineCare for those members who are dually eligible for MaineCare and Medicare, see Prior Authorization Requirements in this Section;

B. The total payment will be no more than the established MaineCare allowance for PMDs;

C. The payment to the provider shall be reduced by any amounts paid by Medicare;

D. MaineCare's allowance in non-assigned cases shall not be limited by the Medicare determination of medical necessity or allowable reimbursement rate; and

E. Services initially prior authorized by MaineCare will reflect a reduction in reimbursement equal to the Medicare average payment. Subsequent adjustments will be authorized following a review of all Medicare Explanations of Benefits or written correspondence.

60.10-10 Payment by the Department for any good or service provided shall constitute full payment for the supplies or equipment furnished and no additional charge shall be made to, or on behalf of, the eligible member, except for required co-payments. Some services and procedures require Prior Authorization in order for MaineCare to provide payment.

60.11 CO-PAYMENT

Co-payment dispute resolution procedures are described in Chapter I of the *MaineCare Benefits Manual*.

60.11-1 Co-payment amount

A. A co-payment will be charged to each MaineCare member who receives Medical Supplies or DME. The amount of the co-payment shall not exceed $3.00 per day for equipment or supplies, according to the following schedule:

MaineCare Payment for Service	Member Co-payment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 - 50.00	$2.00
$50.01 or more	$3.00

B. The member shall be responsible for co-payments up to $30.00 per month whether the co-payment has been paid or not. After the $30.00 cap has been reached the member shall not be required to make additional co-payments and the provider shall receive full MaineCare reimbursement.

C. Members shall not be charged more than $3.00 per month for any rental service.

D. No provider may deny services to a member for failure to pay a co-payment. Providers must rely upon the member's representation that he or she does not have the cash available to pay the co-payment. A member's inability to pay a co-payment does not, however, relieve him/her of liability for a co-payment.

E. Providers are responsible for documenting the amount of co-payments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous co-payments.

60.11-2 **Co-payment exemptions**. No co-payment may be imposed with respect to the following services:

A. All exemptions listed in Chapter I; and

B. All oxygen and oxygen equipment services.

60.12 BILLING INSTRUCTIONS

A. Providers must bill in accordance with the Department's "Billing Instructions for Medical Supplies and Durable Medical Equipment."

B. All claims submitted must include a primary diagnosis code.

C. Providers may not submit separate claims for DME that is considered to be part of the initially authorized equipment.

D. Providers may not bill more than a thirty-four (34) day supply at a time unless otherwise specified in this policy.

E. All claims must be submitted on a CMS 1500 claim form.

**Please be advised that there is no Chapter III for this section of policy. For information regarding reimbursement or Prior Authorizations and coding please visit: https://mainecare.maine.gov/Default.aspx which will contain a link to the HealthPAS portal. Please be advised that only MaineCare providers with a Trading Partners username and password will be able to access the HealthPAS website.