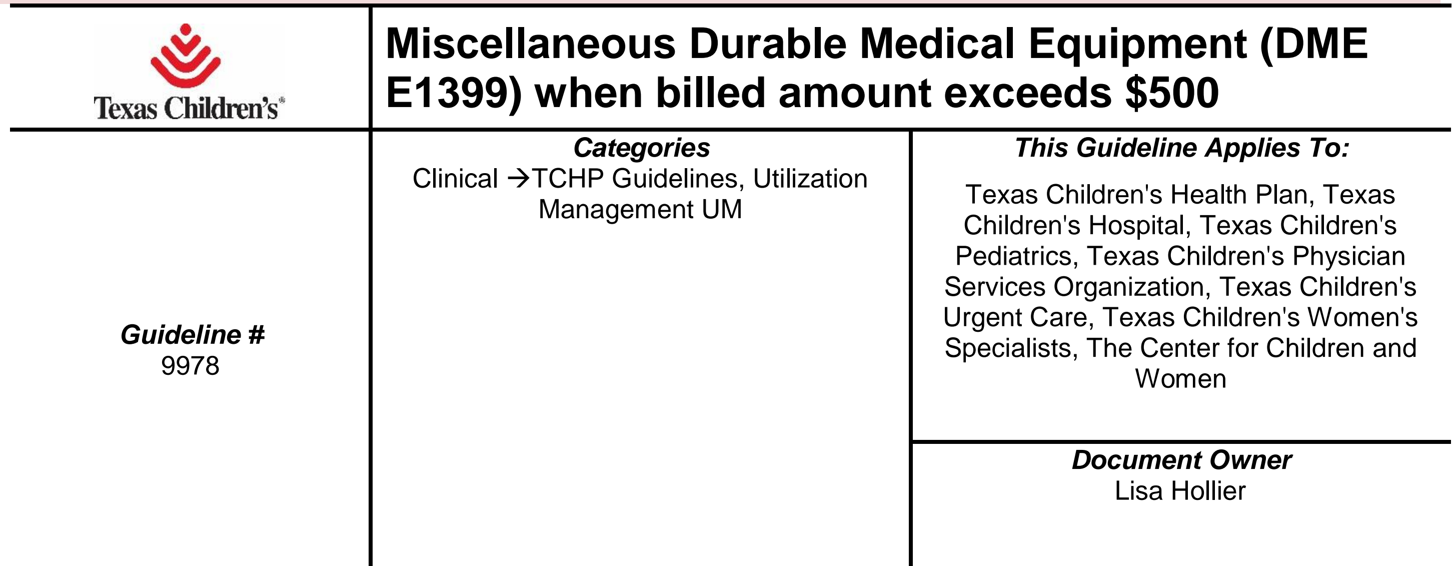

GUIDELINE

Texas Children's

Miscellaneous Durable Medical Equipment (DME E1399) when billed amount exceeds $500

Guideline #	Categories	This Guideline Applies To:
9978	Clinical →TCHP Guidelines, Utilization Management UM	Texas Children's Health Plan, Texas Children's Hospital, Texas Children's Pediatrics, Texas Children's Physician Services Organization, Texas Children's Urgent Care, Texas Children's Women's Specialists, The Center for Children and Women
		Document Owner Lisa Hollier

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of durable medical equipment when billed using code E1399 and A9900 and the billed charges exceed $500.

GUIDELINE

1. E1399 and A9900 are only intended for use when more appropriate codes are not available. When an appropriate code does exist, that code must be used.
2. All requests for prior authorization are received via fax, phone online submission or mail by the Utilization Management Department and processed during normal business hours.
3. To request prior authorization for durable medical equipment when billed using code E1399 and A9900 and billed charges exceed $500, the following documentation must be provided:
   - 3.1. Completed Prior-Authorization form
   - 3.2. Identification and description of the equipment requested to include when applicable:
     - 3.2.1. Invoice with the manufacturer's logo, address and phone number
     - 3.2.2. Equipment model and serial number
     - 3.2.3. Detailed description of the item
     - 3.2.4. Any modifications required, including the product or accessory number as shown in the manufacturer's catalog
     - 3.2.5. Cost or charge for the item(s)

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3.2.6. A detailed explanation of how the requested item(s) differs from an already existing code description if the TMHP manual does not identify this code as appropriate for billing the equipment requested.

3.3. Clinical documentation to support the medical necessity for the equipment requested

3.4. Physician order or prescription, signed by the Physician and no more than 60 days from the date of request

4. Establishing Medical Necessity:

4.1. When applicable – TCHP will follow guidance on medical necessity in the current TMHP manual for the specific equipment requested.

4.2. If the requested equipment is not referenced in the TMHP manual as billable using code E1399 but is submitted under the EPSDT program – TCHP will review the request on a case by case basis and ensure that the requested equipment corrects or ameliorates the client's disability, physical or mental illness, or chronic condition. In addition, the equipment must have a well-established history of efficacy or, in the case of novel or unique equipment, valid peer-reviewed evidence that the equipment serves a medical purpose, can withstand repeated use, and is appropriate and safe for use in the home.

4.3 Any item that qualifies as DME, even if it is a non-payable item, will be reviewed for medical necessity. However, items that do not have FFP (federal financial participation) would be considered benefit denials. These include **exercise equipment, home spas or gyms, toys, therapeutic balls, tricycles, or backup generators.**

5. TCHP may request the following additional information for certain DME items including but not limited to Tricycles, Floor Sitters, Activity Chairs and Corner chairs.

5.1. Effects of the member's condition on their mobility

5.2. Documentation stating how the equipment would correct or ameliorate the member's disability

5.3. Details of any evaluations which have led to the current recommendation, including trials of one or more pieces of equipment

5.4 Pictures of the requested equipment

5.5 Considerations of less costly alternatives

6. Requests that do not meet the criteria established by this guideline will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

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

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exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

REFERENCES:

Government Agency, Medical Society, and Other Publications:

- Texas Medicaid Provider Procedures Manual Accessed December 7, 2020

https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/archives/2020-12-TMPPM.pdf

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Approved	8/06/2020	Clinical & Administrative Advisory Committee Reviewed and Approved for Implementation
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