BlueCross BlueShield of Texas

Home Health Durable Medical Equipment (DME) and Supplies Exceptional Circumstances Provision

What is new

Effective June 1, 2020, the Texas Medicaid Provider Procedures Manual (TMPPM) was updated with information on operationalizing the exceptional circumstances provision for Medicaid clients 21 years of age and older.

Our providers must submit requests for medically necessary DME and supplies not listed as a covered benefit under Texas Medicaid to Blue Cross and Blue Shield of Texas (BCBSTX) through the exceptional circumstances process as outlined in the TMPPM. This process is limited to DME and supplies permitted under federal Medicaid rules.

Prior Authorization Required

BCBSTX requires prior authorization for DME and supplies allowed under the exceptional circumstances provision.

Covered DME and Supplies

There is no exhaustive list of Medicaid covered DME and Supplies. Based on regulation 42 CFR 440.70(b)(3)(v) allowable items include medical supplies, equipment and appliances for use in normal life activities.

Supplies are health care related items: consumable, disposable or cannot withstand repeated use by more than one individual, for medical disability, illness or injury.

Equipment and appliances items for repeated use and reused for medical purposes for our members with disability, illness or injury.

If a member requests an item that could be described as a supply, equipment or an appliance using these parameters, but it is not included as a Texas Medicaid covered item, we should pursue coverage under the exceptional circumstances process. Examples of such items include:

- augmentative communication device (ACD) systems
- bath and bathroom equipment
- bone growth stimulators
- diabetic equipment and supplies
- hospital beds and equipment
- incontinence supplies
- IV supplies and equipment
- mobility aids
- nutritional (enteral) products, supplies and equipment
- PT/INR monitors and related testing supplies
- wound care equipment and supplies

Revised: 01122021

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FAQs Home Health Durable Medical Equipment and Supplies Exceptional Circumstances Provision:

1. Unlike children's Medicaid where we authorize these on the basis of Medical Necessity (MN) as stipulated in the EPDST provision to include all services eligible for Federal Financial Participation (FFP), these services are optional in federal law (not mandatory) for adults, and FFP is typically limited to items covered under the state plan – based on this, what criteria will the MCOs use to determine if the item being authorized is eligible for FFP?

The Code of Federal Regulations (CFR) categorizes Medicaid services as either required or optional. DME is categorized as a required service. Under the CFR, states may create a list of pre-approved DME but may not have absolute exclusions. Instead, states must have a process for requesting items not on the state's approved list. This part of the CFR – Title 42 Chapter 440 – it is not limited to children, and it is this part of the regulation that HHSC is following.

2. How should services be submitted on encounters? How will these items be captured in the FSR and rate setting process for reimbursement to the plans?

For the time being, DME and supplies provided under this provision may need to be reimbursed using miscellaneous DME codes. Health and Human Service Commission is working on a modifier or other identifier can be put in place to allow for better reporting and tracking of these expenditures. Please note that providers should request items of DME with the most appropriate code even though there may be a need to bill with a miscellaneous code.

3. ***Often provider contracts are written to pay a certain percentage of a rate for miscellaneous codes. What can be done to allow providers to be reimbursed at the full rate?***

HHSC suggests following the same process used to reimburse EPSDT services not covered under the state plan.

4. How are MCOs to discern if the items should be covered by a waiver or through this exception process?

Reimbursement under a 1915(c) or 1915(c)-like waiver is always the last resort. HHSC is putting together a comprehensive crosswalk of adaptive aids covered through waivers and how the waiver policies interact with the exceptional circumstance policy.

5. How will this be reconciled in the Utilization Management and Review (UMR) and Office of Inspector General (OIG) audits to ensure we do not get penalized for coverage of an item that is not outlined in the state plan?

This policy is consistent with state and federal regulations. We will be adding these clarifying requirements to the UMCM, which will also provide support to the MCOs. HHSC will coordinate with OIG to ensure they are aware of and understand the exceptional circumstances policy.

6. Does the exceptional circumstances process apply to prescription drugs?

No.

7. Could we get an example of an exception like DME that could not be considered an exception for an adult even if medically necessary?

Under 42 CFR §440.70(b)(3)(v), states may not have absolute exclusions of coverage on medical equipment, supplies, or appliances. States must have processes and criteria for requesting medical equipment that is made available to individuals to request items not on a State's preapproved list.

Have questions:

Contact our BCBSTX Medicaid Provider Service Center at 1-877-560-8055 or contact your BCBSTX Medicaid Provider Network Representative at 1-855-212-1615.