Connecticut Department of Social Services
Medical Assistance Program
Provider Bulletin

PB 2003-113 November, 2003

TO: All Medicaid Providers
SUBJECT: The Definition of and the Determination of Medical Necessity for Durable Medical Equipment (DME)

This bulletin supersedes PB 2002-65.

It has come to the Department's attention that there may be a need for clarification about the process that the Department uses to make benefit coverage determinations for Durable Medical Equipment (DME), particularly in light of the 1999 settlement agreement in DeSario v. Thomas. In this settlement, the Department agreed to provide individual consideration for items not listed on the Department's fee schedule and put forth this policy in §17b-262-672 through 17b-262-682 of the Regulations of Connecticut State Agencies, "Requirements for Payment of Durable Medical Equipment". This bulletin clarifies the process that the Department employs in making decisions on coverage pursuant to these regulations.

Requests for individual consideration must: 1) meet the definition of DME, and 2) be medically necessary and medically appropriate. For prior authorization requests for items already on the Department's fee schedule, only medical necessity/medical appropriateness is at issue

Definition

The first step in the process is to determine whether the item in question meets all of the criteria in the definition of DME as adopted in § 17b-262-673, of the Regulations of Connecticut State Agencies. These state that the item in question must:

1. Withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose;
3. Be generally not useful to a person in the absence of illness or injury; and
4. Be non-disposable

The definition adopted by the Department is identical to that employed by the federal Centers for Medicare and Medicaid Services (CMS) in the administration of the Medicare program. The Department recognizes, however, that one of the purposes of the Medicaid program is to enable each state, in accordance with all applicable statutory and regulatory requirements, to furnish rehabilitation and other services to help eligible families and individuals attain or retain capability for independence or self-care.

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CMS has further elaborated on this definition as it applies to specific items in the DMERC manual (Durable Medical Equipment Regional Carrier manual-Region A). This manual is updated on a regular basis and is universally recognized as a health care industry standard as an aid for the identification of the clinical uses of DME.

While the Utilization Review (UR) staff at DSS does consult the DMERC manual, it is not the only tool that they employ in considering whether a requested item does, in fact, meet the definition of DME. If the item does not appear on the Department's fee schedule and it also is not listed as a covered item in the DMERC manual, staff shall look to other sources of information concerning the requested item. For example, they may request additional documentation from the prescribing practitioner, or they may consult with physicians at the University of Connecticut Health Center under the terms of a Memorandum of Understanding. Under this agreement, the Department may access faculty in the full range of medical specialties to assist in the determination of medical benefits. The staff must then arrive at their own conclusion as to whether the requested item meets the criteria specified in the regulation in order to be considered DME. This would include consideration of any documentation provided to the Department about the particular item requested. Every item shall be individually assessed as to whether it meets the Department's definition of DME. Items are not denied solely because they are in a particular category.

Medically Necessary/Medically Appropriate

If an item has been determined to meet the definition for DME, the second question is whether that particular item is medically necessary and medically appropriate for a particular Medicaid recipient. In making these decisions, the Utilization Review staff at DSS must evaluate the request for a particular item in light of the Department's definitions of medical necessity and medically appropriate. Both assessments must be based on an individualized assessment of the recipient and his or her medical condition, including documentation from the recipient's doctor and other providers and may include communication with the recipient.

In Section 17b-262-673 of the regulations of Connecticut State Agencies, the Department defines "medical necessity" as:

> "Health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health, to diagnose a condition or prevent a medical condition from occurring."

In the same section, the Department defines "medically appropriate" as:

> "Health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities."

The definitions of "medical necessity" and "medically appropriate" must be applied to each individual once it has been determined that the item requested meets the definition of DME. An item could qualify as DME but it may or may not be medically necessary for a given individual. It may be medically necessary for that individual, but it may or may not be medically appropriate depending on whether the UR staff determine, among other things, that the item is "the least costly of multiple, equally-effective alternative treatments or diagnostic modalities."

While the DMERC Manual provides broad guidance for which items meet the definition of DME and when such items can be determined to be medically necessary and/or medically appropriate for an individual client, it is never the sole basis for denial of a request for coverage. It is a reference point, but it is just that. Additional documentation is received, as described above, and the ultimate determination is based on the criteria specified in the Department's regulations, §17b-262-672 through 17b-262-682.

I hope that this bulletin has provided some clarification about the range of activities that we are engaged in to assure that every request for DME receives a comprehensive review for our clients. If you have any questions, please email your questions to Mark Schaefer at mark.schaefer@po.state.ct.us or Evelyn Sebastian at evelyn.sebastian@po.state.ct.us.

David Parrella, Director
Medical Care Administration

This bulletin and other program information can be found at **www.ctmedicalprogram.com**.
Questions regarding this bulletin may be directed to the EDS Provider Assistance Center - Monday through Friday from 8:30 a.m. to 5:00 p.m. at:
In-state toll free.....**800-842-8440** or
Out-of-state or in the
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PO Box 2991
Hartford, CT 06104