Carta Trámite

31 de diciembre de 2024

A: Todos los proveedores Contratados por First Medical Health Plan, Inc., para el Plan Vital

Re: Carta Normativa 24-1227 relacionada a Cubierta de Polisomnografía Diagnóstica

Estimado(a) Proveedor(a):

Reciba un cordial saludo de parte de First Medical Health Plan, Inc., (FMHP).

Adjunto a este comunicado encontrará la Carta Normativa 24-1227 de la Administración de Seguros de Salud de Puerto Rico, (ASES).

A través de esta Normativa, la ASES informa que, se incluye en cubierta el estudio de apnea del sueño o polisomnografía diagnóstica. Esta cubierta se extenderá a aquellos pacientes que el neumólogo determine que está en riesgo de sufrir de apnea del sueño obstructiva, basado en los criterios de la *American Academy of Sleep Medicine*. Es importante seleccionar al paciente para el estudio de polisomnografía luego de recibir varias evaluaciones y cuestionarios, incluidas en este comunicado.

Además, si se establece el diagnóstico y se ha comenzado el tratamiento, la ASES cubrirá la máquina de CPAP y sus correspondientes suplidos según la política de equipo médico duradero (DME) **ASES-OC-2024/P003.**

Para detalles específicos sobre la información provista por la ASES, le exhortamos a leer detenidamente la Carta Normativa 24-1227 y el anejo la Política ASES-OC-2024/P003.

Si usted tiene alguna pregunta relacionada a este comunicado y/o necesita información adicional, siéntase en la libertad de comunicarse con nuestro Centro de Servicio al Proveedor al número libre de cargos 1-844-347-7802 de lunes a viernes de 7:00 a.m. a 7:00 p.m. También, puede acceder a nuestra página electrónica www.firstmedicalvital.com.

Cordialmente,

Departamento de Cumplimiento
First Medical Health Plan, Inc.

CARTA NORMATIVA 24-1227

27 de diciembre de 2024

A: **Organizaciones de Manejo Coordinado de Salud (MCOs) y Proveedores Participantes del Plan de Salud del Gobierno - Plan Vital**

ASUNTO: **CUBIERTA DE POLISOMNOGRAFÍA DIAGNÓSTICA**

La ASES ha determinado incluir en cubierta el estudio de apnea del sueño o polisomnografía diagnóstica. La polisomnografía es la regla estándar para hacer el diagnostico apnea del sueño. La cubierta se extenderá a aquellos pacientes que el neumólogo determine que está a riesgo de sufrir de apnea del sueño obstructiva, basado en los criterios de la *American Academy of Sleep Medicine*.

Los pacientes que tienen factores de riesgo de apnea obstructiva del sueño (AOS) o que informan síntomas de AOS deben ser evaluados, primero con una historia completa del sueño y un cuestionario estandarizado, y luego mediante pruebas objetivas, si está indicado. La prueba de referencia para la AOS es la polisomnografía realizada durante la noche en un laboratorio del sueño. Las pruebas caseras son una opción en ciertos casos.

Los factores de riesgo comunes incluyen:

- Obesidad
- Hipertensión resistente
- Retrognatia (es una afección en la que la mandíbula inferior está más atrás que la superior).
- Circunferencia del cuello grande (> 17 pulgadas en hombres, > 16 pulgadas en mujeres)
- Antecedentes de accidente cerebrovascular, fibrilación auricular, arritmias nocturnas, insuficiencia cardíaca e hipertensión pulmonar.
- Estrechamiento de las vías respiratorias superiores
- Ronquidos fuertes
- Episodios observados de apnea
- Asfixia nocturna
- Sueño no reparador
- Dolores de cabeza matutinos
- Fatiga inexplicable y fatiga excesiva
- Cansancio durante el día

Es importante seleccionar al paciente para el estudio de polisomnografía luego de:

- Examen físico e historial extenso
- Evaluar cuestionario (tales como):

Autorizado por la Oficina del Contralor Electoral OCE-SA-2024-00267

- Berlin12
- Escala de Somnolencia de Epworth o el cuestionario
- STOP-Bang (tabla 1). El cuestionario STOP-Bang es una herramienta fácil de usar que amplía el cuestionario *STOP (**S**noring, **Ti**redeness; **O**bserved **A**pnea and **P**ressure (High blood pressure)* al que se le ha añadido ***B**ody mass index, **A**ge, **N**eck size and **G**ender*

El diagnóstico de AOS se confirma si el número de eventos de apnea por hora (es decir, el índice de apnea-hipopnea) en la polisomnografía o las pruebas caseras es superior a 15 Independientemente de los síntomas, o más de 5 en un paciente que informa síntomas de AOS. Un índice de apnea-hipopnea de 5 a 14 indica AOS leve, de 15 a 30 indica AOS moderada y más de 30 indica AOS grave.

Si se establece el diagnóstico y se ha comenzado en tratamiento, la ASES cubrirá la máquina de CPAP y sus correspondientes suplidos según la política de equipo médico duradero (DME) **ASES-OC-2024 /P003**.

Se requiera a todas las aseguradoras contratadas bajo Plan Vital que cumplan con la inclusión de este servicio y con lo establecido en esta Carta Normativa. Igualmente, cada una es responsable de diseminar esta información entre su red de proveedores y orientarles.

Cordialmente,

Roxanna K. Rosario Serrano, BHE, MS
Directora Ejecutiva

Government Health Plan (GHP) - Plan Vital CLINICAL OPERATIONS AREA			
Policy:	**DURABLE MEDICAL EQUIPMENT & HOME HEALTH SERVICES**		
Number: ASES-OC-2024 /P003	**Review Date:**	**Effective Date: JULY 1st , 2024**	**Number of Pages: 11**
Approved By: Milagros A. Soto Mejía, MHSA, MMHC **Signature:** **Clinical Operations Director**			**Date: Aug**/28/2024
Approved By: Roxanna K. Rosario Serrano, BHE, MS **Signature:** **Executive Director**			**Date: Aug**/28/2024
Reference:	42 CFR. § 410.38, 42 CFR § 440.70		

I. PURPOSE

To expand available covered services of the of the Government Health Plan – Plan Vital (GHP-Plan Vital) by including access to certain Durable Medical Equipment and Home Health Services and to define a standard policy of coverage for these services available as a mandatory benefit under the Puerto Rico state plan.

II. DURABLE MEDICAL EQUIPMENT

For the purposes of this policy, ASES will abide by Medicare's definition of Durable Medical Equipment (DME) and other related terms as stated on 42 CFR Part 410.38, and 42 CFR Part 440.70.

III. DME COVERAGE ELEGIBILITY REQUIREMENTS, TYPES OF DME AND SUPPLIES, & INCLUSIONS/EXCLUSIONS

Durable Medical Equipment (DME) should be prescribed by a doctor as medically necessary due to a patient's illness or injury and intended to serve primarily a home-based purpose. DME should be designed for long-term use. Providers for DME or supplies must be certified to participate in Medicare.

- To access the DME Coverage for the rental or purchase of eligible equipment, a prescription from the beneficiary's physician (PCP/Specialist) must be required along with a medical justification for the specific equipment. Prior authorization will be required for the initial request time when it comes to DME due to a permanent or chronic condition. In the case of a temporary condition that requires DME equipment, such DME will be authorized for a specific period with the possibility of renewal if it is deemed to be medically necessary. **Per 42 CFR part 440.70**, there must be a face-to-face or telehealth encounter between a provider and a beneficiary primarily related to the reason they need DME and must occur no more than 6 months prior to the start of services prior to payment being made. Providers must be certified to participate in Medicare. Per 42 CFR part 440.70, a beneficiary's need for DME should be reviewed at least annually.

  NOTE 1: *Children with Special Needs have enhanced coverage, and the limitations imposed on regular DME coverage do NOT apply. Regarding patients registered under Special Coverage due to special conditions, the coverage is similar to that of DME and Home Care for medical necessity, as the special coverage does not add additional benefits to the regular GHP-Plan Vital coverage.* DME coverage for a child may include customization and modification to meet developmental and medical needs, and to address mobility issues. Also, for support of educational aids and communication aids in school setting and daily activities.

Covered DME includes, but is not limited to:

- ***Audio Assistive Boards / Communication Devices***
- **Blood Sugar Monitors (Flash Glucose Monitors/ Non-invasive Glucose Monitors):** Higher-functioning blood sugar monitors may be excluded unless deemed medically necessary by a prescription from the member's endocrinologist.
- **Blood Sugar Test Strips**
- **Canes**
- **Commode chairs**
- **Continuous Glucose Monitors (CGM) as prescribed by the endocrinologist.**
- **Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BPAP) machines**
- **Crutches**
- **Hospital beds- semi electric**
- **Infusion pumps & supplies**
- **Nebulizers & nebulizer medications**
- **Oxygen equipment & accessories**
- **Patient Hoyer Lifts or hydraulic cranes** – for paraplegic or quadriplegic individuals, patients with mobility limitation, or obesity.
- **Pressure-reducing support surfaces for beds**
- **Suction pumps**: for patients with tracheostomies, respirators, or injuries that prevent or make it difficult to swallow.
- **Feeding pumps**: for patients with Percutaneous Endoscopic Gastrostomy (PEG), and special feeding due to dietary requirements.
- **Nutritional supplements**: specialized formulas and supplements for individuals unable to consume regular food by mouth and fed through PEG. This Policy does not cover supplements accessible over the counter such as "Ensure" or the like.
- **Traction equipment**
- **Walkers**

- **Wheelchair**
- **DMEPOS**: DME Prosthetics, Orthotics, Supplies (medical)
    - Prosthetic devices that replace all or part of an internal bodily organ
    - **Prosthetics,** like artificial legs, arms, and eyes
    - **Orthotics**, like rigid or semi-rigid leg, arm, back, and neck braces
    - **Certain medical supplies required for the use of the DME**, like medications to be used with nebulizers, lancets or testing strips for glucometers, etc.

NOTE 2: *GHP-Plan Vital will typically pay only for standard equipment to meet the justified medical need. Any special features or upgrades will NOT be covered, and the cost responsibility must rely entirely on the beneficiary demanding such features,* ***except under strict prior authorization and medical necessity criteria.***

Items that are for convenience or experimental are EXCLUDED:

- Equipment mainly intended to assist outside the home, like motorized scooters, segways, ramps, widened doors, **Except in pediatric patients**.
- Motorized scooters, segways; outdoors kneeler scooters **except in Achilles tendon rupture and or repair, and severe displaced and with minutes bone fractures of talus and ankle mortise**.
- Most items that are intended ONLY for convenience or comfort like (but not limited to) stairway elevators, grab bars, air conditioners, bathtub, and toilet seats.
- Disposable or single-use items that are not used with equipment. For example (but not limited to):
    - Underpads
    - Gloves
    - Catheters: **May be covered as prosthetics if patient has a permanent / chronic condition.**
    - Surgical facemasks
    - Compression leggings

- However, if a patient simultaneously receives (or as part of) home health care, some of those supplies will be covered, or with strict prior authorization or medical necessity criteria.

- Home modifications such as handrails or grab bars installation, ramps or widened doors to improve wheelchair access.
- Equipment that is not suitable for use in the home. This includes some types of DME used in hospitals or Skilled Nursing Facilities (SNFs), like paraffin bath units and oscillating beds.
- Physical fitness or self-help equipment.
- Devices and equipment used for environmental control.

IV. DME Maintenance & Replacement

The costs for maintenance and repair of the assigned DME will depend on whether the equipment was rented or was purchased. GHP-Plan Vital may also cover replacement of the equipment according to generally accepted time frames. Will cover maintenance when it may be a safety issue resulting in injury due to the lack of such maintenance.

DME may be replaced after a minimum useful lifetime of five (5) years. If the equipment is worn out, GHP-Plan will only replace it if the beneficiary had the item in his/her possession for its whole lifetime. An item's lifetime depends on the type of equipment but, in the context of getting a replacement, it is never less than five years from the date the patient began using the equipment. Or less than five (5) years in some DME according to clinical coverage policy listing https://medicaid.ncdhhs.gov/5a-3-nursing-equipment-and supplies/download?attachment

> **NOTE 3:** *This five-year timeframe differs from the three-year minimum lifetime requirement that most medical equipment and items must meet in order to be considered DME by Medicare. The item must also be so worn from day-to-day use that it can no longer be fixed.*

- *DME for a child may be in perfect condition without wear or operational impact but it no longer "fits" a growing child with a large growth spurt in one (1) year or much less than 5 years.*

Replacing equipment means substituting one item for an identical or nearly identical item. For example, GHP-Plan Vital will cover the switch from one manual wheelchair to another, but it will not pay to replace a manual wheelchair with an electric wheelchair or a motorized scooter, unless deemed medically necessary through the prior authorization review process.

GHP-Plan Vital will pay to replace equipment that was rented or purchased at any time if it is damaged beyond repair, in an accident or a natural disaster (fire, flood, other), if the beneficiary presents proof of the damage. Also, in such cases, the beneficiary may be required to present a new certification of the medical need and a new order or prescription for the DME to be replaced. If the medical equipment provided to a beneficiary was stolen and the actual cost exceeds $250.00, the beneficiary must report the theft to the Police and obtain a complaint number. Additionally, it is the beneficiary's responsibility to provide a valid explanation for the replacement due to loss or theft, as well as to ensure the care, protection, and maintenance of the new item.

V. HOME HEALTH SERVICES

For this Policy, ASES will abide by Medicare's definitions and criteria related to Home Health Services, and as stated in the Code of Federal Regulations: **42 CFR part 440.70**. MCOs should work with their provider network as needed to ensure all areas of Puerto Rico can access home health services.

Home Health Services are a wide range of health care services that can be provided at the home (as defined on 42 CFR part 440.70) for the general goal of treating an illness or injury. Home health care is usually less expensive, more convenient, and just as effective as care provided in a hospital or a skilled nursing facility (SNF). Skilled home health services may include wound

care for pressure sores or a surgical wound, patient and caregiver education, intravenous or nutrition therapy, injections, or monitoring a serious illness and unstable health status. Home health care may help with a patient's recovery, regaining independence, becoming more self-sufficient, maintaining patient's current condition or level of function, or slowing decline.

Home health agencies must meet all licensure standards, including any home health aide supervision requirements. All services provided under the home health benefit need to have prior authorization, be deemed medically necessary, and be prescribed under an approved plan of care, including services for Physical Therapy, Occupational Therapy, and Speech Therapy and medical supplies. **Per 42 CFR part 440.70**, there must be a face-to-face or telehealth encounter between a provider and a beneficiary primarily related to the reason they need Home Health Services within the 90 days prior to or 30 days after the start of services prior to a payment being made.

Home health services are not covered when:

- Beneficiaries are in hospital inpatient settings.
- Furnished only to assist the beneficiary in meeting personal care needs.

Covered home health services include:

- **Medically necessary part-time or intermittent skilled nursing care**
    - The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician or allowed practitioner has determined that the services ordered are reasonable and

necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

- Part-time or intermittent home health aide care may be covered ONLY if also receiving oversight via skilled nursing care at the same time.

- **Evaluation, therapy and training** provided by a psychiatric/behavioral health trained nurse, if or when available.
- **Physical therapy**
- **Occupational therapy**
- **Speech-language pathology services**
  - Physical therapy, occupational therapy, and speech therapy are expected to support a beneficiary regaining their functional level and will operate with the same limitations as PT/OT/ST as defined in the Puerto Rico state plan that are not part of the home health benefit.
- **Education interventions** to foster independence at the beginning of coverage, and for up to three (3) total visits.
- **Medical social services:** These services may be covered ONLY when a doctor or allowed provider orders them to help the patient with social and emotional concerns, that may interfere with treatment or how quickly the person recovers. This might include counseling or helping find community resources. <u>However, it will NOT cover medical social services unless the patient is also receiving skilled care.</u>
- **Home infusion therapy**
- **Injectable osteoporosis drugs for women**
- **Enteral nutrition**
  - An initial prescription for enteral nutrition in the Plan of Care must be provided by a surgeon, a gastroenterologist, or an oncologist, <u>with the recommendation of a licensed dietitian or nutritionist</u>. For further prescriptions, a primary care

physician (PCP) may issue them. However, any changes in the enteral nutrition prescription should be based on the recommendation of a nutritionist.

- **Intravenous chemotherapy**
- **Pain management**
- **Durable medical equipment**
- **Medical supplies for use at home**
- **Incontinence supplies**:
    - The patient's physician must submit written justification to the MCO for approval of these supplies. In adult patients, a Urologist or OBGYN must justify the medical necessity due to a chronic or permanent condition. If a pediatric patient is diagnosed with bowel or bladder incontinence, EPSDT must cover appropriate home medical treatment for this condition, which typically includes diapers or other incontinence products. Diapers will NOT be covered for potty/toilet training. The patient's physician must submit written justification to the MCO for approval.
- **Disposable diapers**: Will be provided by the MCOs, according to the brands of this supply to which they have access. It will not be acceptable to require specific brands of diapers for a patient.
    - It is considered appropriate for the MCO to provide a maximum supply of 3 to 4 diapers per day, for a total of 90 to 120 diapers per month.
- **Urinary catheters**: As medically necessary. For example: patients with bladder outlet obstruction not correctable medically or surgically, intractable skin breakdown caused or exacerbated by incontinence, patients with neurogenic bladder and retention, palliative care for terminally ill or severely impaired incontinent patients for whom bed and clothing changes are uncomfortable. https://www.aafp.org/pubs/afp/issues/2000/0115/p369.html
- **Hygiene supplies such as (but not limited to) underpads, wet wipes, and over the counter ointments are NOT covered.**

Who May Benefit from Home Health Care Services?

GHP-Plan Vital beneficiaries with the following criteria may benefit from receiving Home Health Services:

- Having a "homebound status," as they have difficulty leaving their home without assistance due to illness or injury, or because leaving their home is not recommended given their medical condition; and those not in "homebound status" but with medical conditions that needs to be managed with Home Health Services as described.
- Needing part-time or intermittent skilled services from professionals like nurses, physical therapists, or occupational therapists. (Not solely needed for venipuncture for the purposes of obtaining blood sample). **Must have a specific plan of care duly ordered and supervised by a physician.**
    - The orders on the plan of care must indicate the type of services to be provided for the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.
- Where authorization of home health services is more cost effective than similar services delivered in an inpatient or other setting.

References

1. CMA-Guide-to-DME.pdf (medicareadvocacy.org)
2. "Durable medical equipment (DME) coverage," Medicare.gov, last accessed May 2, 2023, https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage.
3. "Durable medical equipment (DME) coverage."
4. "Equipment and supplies excluded from Medicare coverage," Medicare Interactive, last accessed May 2, 2023, https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/equipment-and-supplies-excluded-from-medicare-coverage.
5. "Eligibility for DME coverage," Medicare Interactive, last accessed May 2, 2023, https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/eligibility-for-dme-coverage.
6. "DME supplier basics," Medicare Interactive, last accessed May 2, 2023, https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/dme-supplier-basics.
7. "Original Medicare DME costs," Medicare Interactive, last accessed May 2, 2023, https://www.medicareinteractive.org/get-answers/medicare-covered-services/durable-medical-equipment-dme/dme-costs-when-you-are-not-affected-by-competitive-bidding.
8. Medicare Benefit Policy Manual Chapter 7 - *Home Health Services, last revision* in 2023; https://www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf.
9. Medicare Benefit Policy Manual Chapter 7 - *Covered Medical and Other Health Services*, revised 2024; https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/bp102c15.pdf