

**DME Task Force Meeting
6/29/2011**

These questions are compiled & edited by Greg Lord of Great Plains Rehabilitation Services, 701-530-4000. Members from the ND MAMES task force will meet NDMA at the North Dakota State Capital in Bismarck on Wednesday, June 29, 2011 at 1:30 pm.

PROVIDERS REQUESTED TO HAVE THE DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES SUBMIT RESPONSES BACK TO THE PROVIDERS FOR REVIEW BEFORE THE 6/29/11 MEETING. RESPONSES COMPILED AND SUBMITTED BACK TO PROVIDERS ON JUNE 24, 2011.

Location: North Dakota State Capital, Judicial Wing, Conference Room D

Attendees: Linda Skiple, Kevin Holzer, Barb Stockert, Steven Jabobchick, Pat Greenfield, Troy Lapp, Jerry Geiger, Jody Anderson, Kurt Schmidt, Greg Lord.

QUESTIONS:

1. Oxygen Equipment

Effective May 8, Medicare changed their process regarding oxygen equipment that is nearing its "reasonable useful life of 5 years."

Per the Medicare system, providers are now to adjust the date of the portable system to that of the stationary system. This is so the two pieces of equipment will "bill together".

In other words...if the portable system is started prior to the stationary...the date is adjusted back or shortened to when the stationary system is started. If the portable system is started after the stationary system...the date is adjusted ahead to the stationary system.

Consequently this might mean that a provider may not receive payment for all 36 months, or that they may receive over 36 months of rent...just depending on when the equipment was started.

Will NDMA be following these rules? It could very likely be an issue when it becomes necessary to replace equipment.

RESPONSE: ND Medicaid follows Medicare policy for oxygen equipment and supplies and will therefore implement the new RUL Policy for Stationary and Portable Oxygen Equipment.

PLEASE REFERENCE: CMS Transmittal 871: Effective date: 5/8/2011
Implementation date: 5/8/2011

SUBJECT: Implementation of New Reasonable Useful Lifetime (RUL) Policy for Stationary and Portable Oxygen Equipment

- Providers will need to indicate initial start dates of both the oxygen concentrator and portable oxygen equipment in the [Explanation of Medical Necessity, Duration of Need and Date of Visit](#) section of the Prior authorization form (SFN 1115) to help prevent any delays in the prior authorization process.

2. CSP & PCCM Referrals

We'd like to have NDMA address the CSP & PCCM referral requirements. I have had a recent conversation with Larry at NDMA regarding a CSP referral that we did not have in place prior to dispensing a lower limb prosthetic in Fargo.

In my conversation with Larry, he stated that the CSP referral would take a "backseat" to the prior authorization that Mary H. had given and that we did not have to worry about being denied payment as the "claims gals" (NDMA) know they do not need to be concerned with the physician names...but are to look for the prior authorization.

Larry said that "they" are aware that there are 3-4 dept's with oversight on these types of things. I used this verbal guidance to confirm this particular order, but it has left us with an uncomfortable position that it will not hold up if denied.

As this is different than what is stated in the NDMA provider manual, Can we have clarification of when referrals WILL be required and when they will NOT be required?

Is it possible to have this information in writing, via an e-mail or, more preferably, in a newsletter to all providers.

RESPONSE: PCP

REFERRALS AND PRIOR AUTHORIZATIONS

Original Referrals

The PCP must generate referrals for specialty care to be received by an enrollee. Referral source documents consist of but are not limited to the use of North Dakota Medicaid PCCM referral form, a statement in a patient's medical records dictated and recorded by the designated PCP, telephone referrals which are documented in the patient's medical record, referral letters, customized referral forms, other insurance referral forms and electronically signed referral forms.

A PCCM referral form may be located and downloaded at:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/managedcare.html>

While RHC and FQHC can be designated as a PCP, these facilities cannot be used as a referring provider on claims. Referrals from these clinics must contain a provider's signature authorizing the referral. This provider must be associated with the RHC or FQHC. IHS facilities have an assigned unique PCP number that is used on the claim when referring.

Primary care provided by a colleague/associate of the designated PCP (during a PCP's absence or inability to see a recipient) does not require a referral from the PCP if the following applies:

- The designated PCP must be associated with the same facility as the PCP. Same facility is defined as a facility that is associated with the Primary Care Provider's facility by having the same Medicaid Provider Identification number as the PCP's facility when submitting a claim.
- The designated PCP must also be that of a type and specialty that may serve as a PCP. For example, if the colleague (located in the same facility) of a PCP is a Cardiologist, this would require a referral.

Walk-In Clinics (urgent care/after-hours/convenience clinics):

Walk-in clinics are “exempt” from PCP referrals only when **BOTH** of the following conditions are met:

1. The Walk-in clinic must be associated with the Primary Care Provider’s clinic by having the same Medicaid Provider Identification number as the PCP’s clinic when submitting a claim.
2. The Medical Center/Walk-in clinic has an electronic health record system in which the Walk-in clinic provider is able to access the recipient’s medical records immediately upon assessing the medical recipient.

When both of these apply during the date of service the recipient is seen, a referral is not required. All other providers are allowed 15 working days from the date of the service to obtain a referral (see Retro-Active Referrals).

Referral Scope and Duration

The services authorized or requested by the PCP indicate the intensity and extent of the referral for specialty care. For example, a referral stating, “diagnose only” is valid for one office visit and a referral stating, “diagnose and treat” is to the conclusion of the treatment. While most referrals will express or imply the period of time the referral is effective, it is the judgment of the PCP as to the length of the referral period. It is the Department’s policy that referrals be effective for no more than one year. The original referral is also applicable for secondary and tertiary services. For example, a PCP refers an enrollee with possible lung cancer to an oncologist for “diagnosis and treatment” (primary referral). The oncologist refers the enrollee to a surgeon for surgical resection of the lung (secondary referral). The original referral from the PCP covers the secondary referral for surgery.

Retroactive Referrals

Retroactive Referrals are not allowed for services stated in the Covered and Non-Covered Services section, with the exception of walk-in and urgent care. For walk-in and urgent care, the provider must have a referral before the claim is submitted for payment. A grace period of 15 working days from the date of service is allowable in these situations.

RESPONSE: CSP

SERVICES OBTAINED FROM A NON-DESIGNATED PROVIDER

Medicaid will not pay for services obtained from a non-designated provider, visits to the emergency room that are determined non-emergent or services obtained without a referral from the recipient’s CSP provider. Specific services are payable without a referral from the recipient’s CSP provider. For a list of services that **do not** require a referral from the recipient’s CSP provider, please contact the Division and ask for a CSP representative

Contact Tania Hellman or Galen Hanson

3. Pulse Oximeter

We need clarification. Will NDMA cover the cost of a rental on a pulse oximeter if the intent/goal is to wean the child or infant off of the supplemental oxygen? (This is always a respiratory goal when oxygen is involved.)

RESPONSE:

PULSE OXIMETER/SUPPLIES

(0445, A4606)

Prior authorization required.

Coverage allowed if any one of the following is present:

- Recipient is dependent on both a ventilator and supplemental oxygen.
- Recipient has a tracheostomy and is dependent on supplemental oxygen.
- Recipient requires supplemental oxygen and has unstable saturations.
- **Recipient is on supplemental oxygen and weaning is in process.**

– Continuous read oximetry meters and any meter used for diagnostic purposes are not covered.

Follow guidance in DME manual

4. NDMA Time-line for New Equipment

Currently ND Medical Assistance allows the purchase of most equipment as one every seven years. This includes walkers, nebulizers, etc.

This time period is out of line with every other insurance company including Medicare. The insurance/manufacture standard (across the board) is equipment can be replaced once every five years. This is also recommended by the manufacturer for most equipment.

Why does NDMA differ from the insurance/manufacture standard? Is this something that can be considered to change?

RESPONSE:

We would like to have an open discussion with providers on this subject. Per DME fee schedule, nebulizers, wheelchairs, TENS, are allowed to be replaced every 5 years, walkers, canes, crutches every 7 years, while hospital beds, standing frames, Airway vest system, Gait trainers are every 10 years. Please reference the online fee schedule for replacement timelines.

Incorrect: DME fee schedule indicates replacement on Oxygen equipment is allowed every 7 years. It is allowed every 5 years if the recipient chooses to replace at that time. Follow Medicare guidelines. Corrections will be made to the fee schedule;

If repairs are going to exceed 75% of replacement, NDMA will consider replacement; however, this is determined on a case by case basis

Does FDA give any guidance? Not that aware of

Gait trainers for children and the 10 years replacement policy: If the equipment is outgrown and there is no more room to make growth adjustments to the equipment, we take that into consideration. Please provide supporting documentation or have the documentation in the client records in case of an audit.

5. Power Assist Rims

We have received denials on E0986 - power assist rims. (Please see below description of this item.) This is an option for a patient that has an existing K0005 chair. The alternative option for these patients is a power chair. Unfortunately some patients are not acceptable of the power chair for various reasons. One reason is the transportation of a power chair. Some patients do not have the means to provide a vehicle to transport a power chair. If they were able to simply add power assist rims to their manual chair they would still be able to transport their chair in a regular vehicle. Please consider approving this item for patients that truly qualify so they may remain as independent as possible. Thank you for your consideration.

A PAPA (push-rim activated power assisted wheelchair) is an alternative to a manual high strength ultra-light weight wheelchair or power wheelchair for individuals if used as part of a rehabilitation plan designed to increase the patient's functional abilities, prevent medical complications and have expressed a preference for still pushing on the wheels of their existing manual high strength ultra light wheelchair.

This chair is generally used by someone who is not strong enough to efficiently propel a manual high strength ultra light wheelchair but wants to be more active than a power chair allows him or her to be. Overall joint range-of-motion was found to be significantly lower when participants used the PAPA. The use of PAPAs reduced the energy demands, stroke frequency, and overall joint range-of-motion when compared with manual high strength ultra-light wheelchair propulsion. When using a PAPA, an individual pushes less often and with less range of motion than with their own high strength ultra light wheelchair, thereby decreasing the likelihood for the development of repetitive strain injuries and upper extremity pain. Transport of a power wheelbase was another limiting factor when choosing the PAPA system. A vehicle that provides capability to transport a power wheelbase is outside the financial capability of most users. The PAPA system can still be transported in most motorized vehicles.

RESPONSE: Please provide additional information to the department for consideration of coverage. Please provide written documentation.

- ✚ What other insurance/TPL covers this code (BCBS, Medicare, other Insurance, What other State Medicaid's cover
- ✚ What is their coverage criterion?
- ✚ What is the potential cost savings to the department vs. a power wheelchair?
- ✚ How reliable are the power assist rims?
- ✚ How durable are they to withstand the ND terrain and ND winters?
- ✚ If recipients need repairs or technical assistance who will provide them with the repairs?
- ✚ If the wheels need to be sent in for repairs how reliable is the vendor and will they provide replacement on loan?

- ✚ What have been the average repair costs you have seen with the E0986?
- ✚ What is the battery life expectancy? And the average battery cost per year?
- ✚ Is this the least costly alternative to meet the recipient's medical need? vs. power wheelchair?

6. Shipping Charges

With transportation costs on the rise we would ask that NDMA consider including shipping charges in the acquisition price for miscellaneous items.

In many cases the "cost plus 20%" does not pay for the resources we have invested into the claim. Acquisition costs are the cost that a company recognizes on its books for property or equipment after adjusting for discounts, incentives, closing costs and other necessary expenditures associated with the acquisition of the product(s).

RESPONSE: Our policy will remain that costs incurred for shipping and handling are considered to be a part of the DME provider's overhead/business expenses. Separate shipping and handling charges will not be allowed and cannot be billed to the recipient.

7. PCP on the Claim

Where is the PCP information supposed to be placed when a claim is submitted electronically? Whenever a patient is required to have a PCP with ND Medicaid, the claims as code 38 - non-authorized provider - Services not provided or authorized by designated (network/primary care) providers.

RESPONSE: The PCP belongs in the referring field. For electronic claims, the provider software varies, and the field is specific to the software. The provider(s) should contact Juli Johnson so the specific issue can be researched.

It doesn't make a difference if the ordering doctor is the PCP, or if we have a referral on file and we change the referring doctor to the PCP information. This is for an electronic claim or a crossover. No matter what the situation is, we always have to print the claim and mail the hardcopy invoice.

We've been told by NDMA Provider Services Rep that either the PCP information is missing or is invalid.

RESPONSE: We would need to see examples.

We've tested different scenarios, but nothing seems to solve the problem other than mailing a hardcopy.

RESPONSE: We would need to see examples.

8. Prior Authorization Time-line

What is the expected turnaround time for a prior authorization? We are seeing some of these take up to 30-60 days to get approvals back.

RESPONSE:

It would depend if the prior came in with errors or not. This would obviously delay the process.

It has been however been taking longer than the usual 2-3 weeks to get priors adjudicated and entered into the system due to the volume of priors coming in as well as 2011 flood efforts. The Division apologizes for the delay.

9. Medicare Coinsurance on Maintenance & Service

Since Medicare is now paying for maintenance and service checks (E1390MS), we are wondering if NDMA is going to consider paying for these service checks and the Medicare coinsurance on these checks.

RESPONSE: ND Medicaid follows Medicare criteria for Oxygen equipment and supplies. The reimbursement rate is \$40. Maintenance and services will require prior authorization to be in place for proper payment to take place.

DME Happenings

• THIS IS WRITTEN NOTIFICATION OF MEDICARE CHANGES

May 2011 | Issue No. 31

Effective for certain oxygen equipment (i.e., oxygen concentrators and oxygen transfilling equipment) but not for other gaseous or liquid oxygen equipment (stationary or portable), a maintenance and servicing fee can be billed with the "MS" modifier and is paid every 6 months, beginning 6 months after the 36th paid rental month or end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later.

The maintenance and servicing fee will be updated on an annual basis through program instructions based on the covered item update for DME. The payment covers all maintenance and servicing through the following 6 months that is needed in order to keep the oxygen equipment in good working order. A single payment (**\$41.20 for dates of service July 1, 2011, through June 30, 2012**) is made per beneficiary regardless of the number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment), regardless of when the maintenance and servicing is performed during each 6-month period, and regardless of how often the equipment must be maintained and serviced. The supplier is required to make at least one maintenance and servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period. These changes are discussed in Change Request (CR) 7248, issued by CMS on January 24, 2011.

10. NDMA Computer System

When is the estimated date that the new NDMA system will be up and running?

RESPONSE: On June 21, 2011, the Department testified in front of the Budget Section of the Legislature. According to that update, “The Medicaid Systems Project continues to be impacted by delays in the completion of the ACS base Enterprise Medicaid Management Information System (MMIS). The base Enterprise MMIS is the foundation upon which the North Dakota MMIS will be constructed. Due to these delays, the June 2012 implementation is no longer viable. We are working with ACS regarding the revised schedule. ACS will appear before the next Budget Section to explain the reasons for the delay and provide additional insight into the anticipated completion of the North Dakota system.”

11. Group 2 Power Wheelchair Rental

As of January 1, 2011 all Group 2 power wheelchairs are now a capped rental item (13 months) through Medicare without the option for first month purchase. How is Medicaid going to handle this billing process? I'm enclosing a copy of all Group 2 codes with the Medicare fee schedule for each code (Exhibit 11, sent via U.S. mail).

RESPONSE: Page 18 of the DME Provider Manual

RENTAL/PURCHASE

- All rental items need to have prior approval.
- North Dakota Medicaid will purchase equipment when it is expected to be most cost-effective.
- After the 12-month rental period, the Medicaid recipient will be deemed to own the item and the supplier must transfer ownership of the item to the client (Exception: Oxygen Equipment. Allowed to rent for 36 months). The supplier providing the item in the specified rental period is responsible to transfer ownership to the client.
- Any Department approved piece of equipment that will be rented by the clients primary payer will also be rented by Medicaid provided the Department has determined medical necessity and the item is covered.

12. Custom Seating Allowable

This was addressed at the last meeting and no determination was given at that time and was still being considered. What decision has been made for increasing the current allowable of “cost + 20%?” ND MAMES providers would consider “cost + 35%” (such on other chairs). Please review the last information given to NDMA to substantiate this.

RESPONSE: Erik and Mary have met and are in the process of pulling claims data and completing an impact analysis. Erik will present the request and gathered information to Management in the near future. If a decision is made before the next DME Task Force meeting a notice will be posted on the Provider Update Link via the Department Website informing providers of the decision.

13. Gait Trainers E8000-E8002 (Posterior, Upright and Anterior):

The current allowable for these codes is \$920.23 (including all accessories) for all three pieces of equipment. But yet they are all considerably different in nature and need. Not all options are chosen with each particular individual and are specific in need.

There are usually multiple sizes in each category and the MSRP usually increases with the larger size chosen.

I'm enclosing one price quote for each HCPC code. Can the allowable be changed to reflect a fair rate of reimbursement for each code so the appropriate piece of equipment can be provided (Exhibit 13, sent via U.S. mail)?

RESPONSE: Erik and Mary have met and are in the process of gathering additional information to present to Management. If a decision is made before the next DME Task Force meeting a notice will be posted to the Provider Update Link via the Department Website informing providers of the decision.

14. Enteral "Duplicate"

We are having trouble with enteral products denying as "duplicate" in the NDMA system. We are assuming that the span dates are overlapping and the NDMA system is automatically rejecting them out as duplicate.

For example one month is 2/15/11 to 3/14/11 and the next month the patient may need to get the product on 3/13/11 (because it's a Friday and we are closed for the weekend).

So then we would span that month 3/13/11 to 4/12/11 and the NDMA system will reject it as duplicate.

Medicare allows providers to deliver enteral supplies up to five days early. We then have the problem of Medicare paying and when it crosses over to Medicaid it denies as duplicate.

What can be done to solve this problem?

RESPONSE: The current MMIS is 30+ years old. It cannot be modified to handle overlapping spans of dates. If a claim is denied as a duplicate, it will need to be adjusted with notes indicating it is not a duplicate and explaining the early fill.

- Can the provider(s) please bring examples (do NOT use individual names or number but rather the denial reason/code/number) so we can review and discuss. Providers should call Provider Relations to find out the specific reason the claim is denying rather than assuming that the span dates are the reason.

Additional discussion:

External Insulin Infusion Pump: New policy will be added to the DME manual

3% increase as of July 1st to the DME Provider fee schedule

Oxygen audit: Make sure you have documentation to back up what you are billing

Shower chairs/Tub Stool: New policy will be added to the DME manual