

## DME Task Force Meeting November 14, 2013

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Location: North Dakota State Capitol in Bismarck  
Judicial Wing 2<sup>nd</sup> Floor - AV room 212

Time: 1:30 p.m. to 3:30 p.m.

Medical Services General Statement: The main purpose of the DME Task Force Meeting is to be a working group to discuss current policy and to bring recommendations to the table for Medical Services to take into consideration. It is not meant to discuss individually denied cases. The Department's decisions are based on 42 CFR 440.230(d) and the North Dakota Administrative Code 75-02-02-08, which allows the Department to place appropriate limits on services based on such criteria as medical necessity or utilization control procedures.

**Attendance:** Greg Lord – Great Plains/St. Alexius  
Barb Stockert – Sanford  
Brenda Schulz - Yorhum  
Steve Richards – Sanford  
Gail Urbanec – Medquest  
Pat Greenfield - Medquest  
Kevin Holzer – Great Plains  
Kurt Schmidt – Great Plains  
Linda Skiple – CPAP Store

Tammy Zachmeier – Medical Services  
Tammy Holm – Medical Services  
Larry Stockham – Medical Services  
Jennifer Sands – Medical Services  
Nikki Lyons – Medical Services

### Documentation Questions

#### Repairs

1. Do ND MAMES providers need to gain an annual physician's prescription for repairs? Current policy states that we don't need it...but there is conflicting feedback from NDMA.

#### **Response:**

NDMA does not require an annual physician's prescription for equipment repair. A copy is required to be submitted when submitting a prior authorization for repairs.

The provider must maintain detailed records describing the need for, and nature of, all repairs, including a detailed explanation containing justification for any component or part replaced, as well as the labor time.

### **Claims Processing & Provider Relations**

1. When leaving messages for NDMA Provider Relations, may we leave more than one request per phone call? There seems to be some inconsistency when messages are left as sometimes calls are not returned when more than one request is left. Please provide advice as to the most efficient way to get answers to provider questions. Also, what is the reasonable expectation for a return call? Sometimes, ND MAMES providers are waiting three to four days for a returned call.

See response below.

2. Could the method of NDMA claims processing be explained? Some claims are processed within a couple weeks and some take up to six months or more. It seems not to matter the complexity of the claim or if it was electronic or paper.

#### **Response:**

When calling Provider Relations, providers are allowed to leave up to 3 recipients per message. We recommend that if a provider has more than 10 recipients total they fax a status request into Provider Relations and they will research the request and get back to the provider as soon as possible. This helps reduce the phone request backlog. Calls are returned within 24-48 hours depending on the volume of calls. Calls are returned in the order they are received.

Claims are processed in the order they are received. Electronic claims are always more current as these claims do not have to be scanned. Paper claims do take longer as these claims have to be scanned and verified manually. We are currently processing claims received on October 23, 2013 for electronic, and for paper we are processing claims received on October 3, 2013. We are typically out 4-6 weeks in DME processing. If a provider has claims that are older than what we are currently processing we suggest they contact us to check the status. Please keep in mind we process claims based off the received date of the claim, not the date of service.

#### **Additional Discussion:**

Provider Relations has been logging 200 plus calls daily from doctors, recipients, etc.

Providers stated that they appreciate the NDMA efforts to decrease DME prior authorization to two weeks if submitted correctly.

### **Power Tilt / Recline and Power Elevating Legrests**

1. We would like to have NDMA review the coverage criteria for the E1007 which is power tilt/recline and E1010 power elevating leg rests. NDMA states they follow the Medicare guidelines. Medicare covers both these codes and there are very legitimate medical reasons for patients to receive these features/services. Written justification has been sent to Tammy Holm for the utilization team to review. It has been denied by Medicaid but we feel that by not covering these codes it's really an injustice to the patients.

**Response:**

NDMA follows existing NDMA DME coverage/policy criteria regardless if there is a primary payer or not. In cases where there are not existing NDMA coverage/policy criteria, NDMA will then generally follow the primary payer policy.

The UR team received and reviewed the requests to add the power tilt/recline (E1007) and power elevating leg rest (E1010) to the DME manual and fee schedule. The recommendation of the UR team was not to add to the current DME wheel chair/accessories policy at this time.

**Additional Discussion:**

NDMA encourages providers to reference the "Exception Request" section of the DME Provider Manual, located on page 21, for guidance when submitting prior authorizations for non-covered items.

When reviewing exception requests, NDMA will reference similar DME policies criteria.

If NDMA approves an exception request, NDMA will set the item's allowable fee.

When submitting an exception request for a non-covered item, please utilize its recognized HCPCS code, for example code E1007.

Greg Lord agreed to collect data from the providers on the frequency of HCPCS codes E1007 and E1010 submitted to NDMA for review.

**Submitting Enteral/Diapers and Span Dates**

1. After a meeting with Great Plains & NDMA in February, 2013, it was discussed and decided that a list of 'B' codes (enteral) & the A4520 (diapers), would be set up with NDMA to allow a five day grace period. If a patient receives their supply one to five days early due to vacation, weekend, etc., NDMA would not deny the claim submitted for payment. This process was working up until a few weeks ago. Once again, these claims are denying as duplicate processing due to receiving the item before their anniversary date. A NDMA staff member informed us that "no decision" had been made that product can be provided within the five days of their anniversary date. The suggested solution is to submit the claim, let it deny as duplicate, submit adjustment asking to reprocess noting the explanation as to why they received the supplies early. This means that every claim will need to be submitted as a paper item, which takes much longer for processing. This could be a 6+ month course. That process would be a huge waste of time by both NDMA and ND MAMES providers.

**Response:**

The current MMIS cannot be modified to accommodate 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. Providers should not modify dates of service on the claim. The correct dates of service need to be billed.

When billing claims to North Dakota Medicaid, be sure to include the “5-day leeway” in box 19. By supplying this information on each claim it will prevent the claim from denying and the need for an adjustment.

Contact information for questions regarding claims are as follows:

- Provider Relations is your first point of contact at 328-4043.

**Additional Discussion:**

The current MMIS is not able to accommodate overlapping span dates. This issue will more than likely be carried over to the new system.

It is very important that when submitting the CMS-1500 form for payment, the provider include the notation “5 day leeway” in box 19 on the form, or it will be denied as a duplicate service.

NDMA cautions providers that the “5 day leeway” remark cannot be used for every month as this will result in exceeding the limits of supplies.

**Breast Pumps**

1. With the increase in baby deliveries in North Dakota and the coverage of breast pumps for nursing moms, will there be any consideration to increasing the fee schedule to purchase an electric pump for NDMA beneficiaries? At this time, the ND MAMES provider cost is more than reimbursement on these items.

**ND NAMES ADDITIONAL RESPONSE**

7 Providers submitted the Make, Model and price for the breast pumps that they carry. The manufactures were Evenflo, Medela, Amenda for manual, electric, and hospital grade breast pumps with the prices.

**Response:**

NDMA has reviewed the list that the providers have sent with the breast pumps for manual, electric and hospital grade pumps. In review of the list, it appears that most providers prefer to offer the Medela brand or brands of a higher value. The description for HCPCS code E0603 is “*BREAST PUMP, ELECTRIC (AC AND/OR DC), ANY TYPE*”. This description allows the provider to offer any brand that meets the description and that falls within the allowable guidelines. The current fee schedule amount will continue to be followed at this time.

**Additional Discussion:**

Providers voiced concerns that referring professionals are requesting Medela breast pumps for Medicaid recipients because in the referring professional’s opinion, this is a better product.

NDMA encourages the DME providers to share with the referring professionals that NDMA does not mandate what brand/make the providers carry, nor is the hospital grade pump considered a medically necessary replacement for the personal breast pump.

Providers asked if they offered another brand, what should be their course of action if the brand they offered has performance issues.

NDMA recommended that the provider contact the manufacturer, as they would with any other product that has performance issues.

Providers asked for clarification if Medicaid recipients are also eligible for WIC.

NDMA confirmed the Medicaid recipients are also eligible for Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

### **CPAP Transition**

1. If a patient has a CPAP that was purchased through insurance and is now on Medicare but does not meet the coverage criteria, we will have them fill out an ABN for the supplies they receive? If Medicare denies with a PR denial, and the patient has NDMA as a secondary, will the claim deny from NDMA with a patient responsibility as well?

#### **ND NAMES ADDITIONAL RESPONSE:**

The patient received a CPAP under a commercial insurance plan and had an AHI of 3.2 and RDI of 8.4 on their sleep study. The commercial insurance plan paid for the CPAP.

The patient is now 65 years old and is on Medicare. The patient's sleep study does not qualify them for a CPAP or supplies under Medicare program guideline (AHI of 5 or greater). However, the patient wants & needs ongoing CPAP supplies and is willing to pay for the supplies out of pocket.

The provider assists the patient in filling out an ABN (stating the item could be submitted to Medicare but they do not meet coverage criteria). The provider receives a "PR" denial from Medicare (claim was submitted with a "GA" modifier). A Medicare PR denial allows the provider to bill the patient for "medically non-covered" services.

We are questioning that if a patient has NDMA secondary in this scenario, are we able to directly bill the patient for the Medicaid secondary portion...since the supplies were determined to be "not medically necessary" by Medicare

#### **Response:**

Based on the example above, this would be considered non-covered per the NDMA UR process based on the departments coverage guidelines.

NDMA would recommend providers reference the General Provider Manual with any TPL issues or when it is allowable to bill Medicaid recipients.

Per guidelines referenced in the General Provider Manual, page 39-40:

**WHEN CAN I BILL A MEDICAID RECIPIENT DIRECTLY?**

*In most circumstances, providers may not bill recipients for services covered by Medicaid. The exception is that providers can bill recipients for co-payments and recipient liability (RL).*

*More specifically, providers cannot bill recipients directly:*

- *For the difference between charges and the amount Medicaid paid.*
- *When a third-party payer does not respond.*
- *When the provider bills Medicaid for a covered service and Medicaid denies the claim because of billing errors.*

*Providers may bill Medicaid recipients directly under the following circumstances:*

- *For co-payments. Providers may choose to collect recipient co-payments at the time of service or bill the recipient later.*

- *For recipient liability amount documented on the remittance advice. Providers (with the exception of Point of Sale Pharmacy) may not collect RL at the time of service.*

- *For services not covered by Medicaid, as long as the provider and recipient have agreed prior to providing services.*

- *If a provider chooses not to enroll as a Medicaid provider, the recipient is responsible for all charges.*

- *When services are being provided free to other individuals, Medicaid may not be billed for those services either.*

**Ventilator Discussion**

1. ND NAMES would like to have an open discussion with NDMA on ventilators and their coverage. Will NDMA not consider coverage for a second ventilator that is used as a backup?

**Response:**

Generally, in cases of purchase of a ventilator for a Medicaid recipient in the home, one ventilator is purchased by Medicaid with a third party insurance assisting with a backup ventilator. Each case is reviewed independently for medical necessity.

**Additional Discussion:**

Discussion was discontinued as it mainly concerned one specific Medicaid recipient and the purpose of the meeting is not meant to individual cases.

NDMA is aware of this unique case and is currently working with all parties involved. NDMA will contact provider(s) whose services are pertinent to the development of this Medicaid recipient's plan of care based on their medical issues.

2. Why is there not a NDMA ventilator program for children? There have been many children from North Dakota that are hospitalized at Children's Hospital in Minnesota and cannot get back to North Dakota because of limited DME and nursing coverage for them provided by North Dakota (coverage that meets the Minnesota requirements for discharge).

**Response:**

Currently, NDMA has a ventilator dependent waiver for individuals 18 and over. NDMA does not have a waiver for children specific to ventilators. North Dakota does provide additional home health hours for cases of children in the home to supplement the care of the parents up to the highest nursing home cost per month. The rate for the extended hours for RN and LPN home health is negotiated with the home health agency

This topic will be added to the next Pediatric Task Force meeting agenda for further discussion.

**Additional Items:**

Update on Prior Authorization issues and trends as listed below:

- All SFN 1115 must be typed or will be returned without being processed.
- Prior Authorization and Adjustment completion guides are posted on the DME Provider website. Please see the following website links:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/dme/dme-pa-guide.pdf>

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/dme/dme-adj-guide.pdf>

- Place of residence must be current and accurate
- Missing or incorrect information :
  - No Provider/Physician signatures
  - Incorrect or missing Provider/Physician number
  - Modifiers on prior authorization and claims
  - Stop dates – a one-time purchase NDMA allow 6 months
  - Invoices
  - Months of rental prescribed
    - 99 months is not appropriate. Need to use 3, 9, or 12 months; unless O2 which needs to indicate 36.
- Duplicate prior authorizations are being received.

- Please allow 3 weeks before calling Provider Relations to inquire on the status of a prior authorization. The prior authorization may have been adjudicated and entered recently and notification has not been received.
  - All prior authorizations are reviewed in the order they are received and then forwarded to claims for processing.
- Contact Provider Relations (701-328-4043) for questions regarding:
  - Recipient eligibility
  - Payments
  - Denials
  - General claim questions
  - Billing instructions
  - Status of prior authorizations
- Please remember to use your departments correct fax number, which allows us to be more efficient in the return process.
- Please remember, if a Medicaid recipient is receiving Home Health services, the supplies needed for these services are **not** to be billed to Medicaid as are included in the Home Health service rate and are not covered separately.
  - NDMA would recommend that providers reference the General Provider Manual "HOME HEALTH PRIVATE DUTY NURSING" section for guidelines, page 56-62.

**Open Floor Discussion:**

1. Why does NDMA pay for diapers for children?
  - The NDMA incontinence policy states recipients under the age of 4 are not covered.
2. Is there a way the providers can have the list of suspended claims sent to them automatically?
  - Yes, please contact Provider Relations at (701) 328-4043 or (800) 755-2604 for assistance.
3. On the SFN 1115 form, does the physician section need to be typed?
  - No, as stated in the prior authorization completion guide.
4. Can a provider ask for expedited review of a prior authorization in special circumstances?
  - Yes, NDMA does allow for an expedited review in special circumstances.

5. Is NDMA going to require the Medicare "Face-to-Face" encounter requirements for DME items?

- Yes. NDMA has posted information on the "Provider Updates" section of our website that states NDMA will follow the Medicare "Face-to-Face" requirement extension. NDMA will review the Medicare DME "Face-to-Face" encounter requirement list to determine which items NDMA will also require this prerequisite on.

6. Providers asked if possible to receive a NDMA response to their questions prior to the actual meeting to stimulate discussion.

- Yes, but the deadline for the questions may need to be set earlier to allow NDMA adequate time complete their response(s).

**Update to Providers concerning the Recovery Audit Program (RAC) and how it relates to DME**

Larry Stockham - Medicaid Program Integrity Audit Coordinator

Please note that we look very closely at every type of recovery the RAC suggests. Even though we want recover any overpayments, we also want to be fair to the providers.

Maggie has also stated that we will not seek any neutral recoveries, meaning that if the claim may have not been technically correct, but we would have still paid the same even if it had been billed correctly, then we won't seek that recovery. This applies mostly to coding rules. The RAC is looking at over limit errors where there wasn't a prior authorization and have annualized the limits.

NMDA is in the process of finalizing the error codes. Don't expect any RAC letters being sent out before Mid-December or possibly the first of the year.

Providers are advised to utilize the appeal process afforded by the RAC as they find appropriate.

North Dakota Provider Enrollment is aware of the new DME law submitted by the State Board of Pharmacy.

**NDMA would like THANK ALL OF THE DME PROVIDERS for their efforts in submitting "clean" prior authorizations. As a result of the provider's efforts, NDMA's efficiency in processing prior authorizations has increased. This allows DME providers and North Dakota Medicaid recipients to receive their notification letters sooner.**

**The DME providers are applauded for their services and the continued dedication that they provide for our NDMA recipients.**