

DME Task Force Meeting 11-15-2012

*Location: North Dakota State Capital in Bismarck
Judicial Wing 2nd Floor - AV room 212
Wednesday, November 15, 2012 at 1:30 pm*

Attendance:

Greg Lord – Great Plains/St. Alexius	Eric Elkins – Medical Services
Barb Stockert – Sanford	Cindy Sheldon – Medical Services
Brenda Schulz - Altru	Meagan Heckaman – Medical Services
Russ Nylander – Sanford	Tammy Holm – Medical Services
Gail Urbanec – Medquest	Barb Koch – Medical Services
Kevin Holzer – Great Plains	Michele Adams – Medical Services
Jody Anderson – Altru	Linda Skiple – CPAP Store
Pat Greenfield – Medquest	

Documentation Questions

1. Why is NDMA requesting new documentation, when they have been covering & paying for an item for a number of years? An example is enteral supplies. All of a sudden, NDMA is requesting documentation to renew the prior authorization. This is happening even in situations where a CMN is completed annually and signed/dated by the prescribing physician.

Response:

The purpose of the CMN is to be a quick reference guide to policy criteria (a user aid) not a replacement for medical documentation. The CMN is not an all-inclusive guide for NDMA coverage criteria. Therefore, a CMN is not a replacement for medical documentation.

NDMA has been flexible in allowing physicians to utilize a CMN of their preference, which will at times require additional medical documentation to support medical necessity.

NDMA is experiencing an increase in incomplete CMNs: no medical documentation requires the return of the prior authorization, which delays the process.

NDMA continues to utilize the same prior authorization process per Department policy criteria for all new or re-certification prior authorization requests. By doing so, this shows NDMA is in compliance with Federal regulations during a Department's Surveillance/Utilization Review Section (SURS) or a Recovery Audit Contractor (RAC) audit.

Additional Discussion:

Additional documentation may be related to a patient's change in condition. The additional requested medical documentation supports the Department and the Provider in showing compliance during a Surveillance and Utilization Review Section (SURS) or Recovery Audit Contractors (RAC) audit.

2. NDMA is approving a ND MAMES provider's s prior authorizations for certain shoes for foot & toe deformities. However, lately NDMA is also including verbiage "ONLY IF PRIMARY PAYS". Medicare has NEVER paid for codes L3221/L3222/L3216. NDMA previously ALWAYS paid for these items. The provider cannot find a NDMA published notice to suggest that NDMA has discontinued paying for these items. This change may be putting the NDMA beneficiaries with foot & toe deformities at a health risk. The provider can provide examples should NDMA want to see them.

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Response:

As of November 1st, 2012, NDMA will provide concise verbiage of "Please bill all other insurance prior to Medicaid" rather than "Only if primary pays."

L3222 is a non-covered item that is not on the Department fee schedule from 7/1/2011 back to 2009. The proper way to verify coverage of a specific item is to reference the Departments fee schedule as a general guide. Checking the fee schedule for coverage is a good overall guide, however, it is not absolute. If you have a coverage question on a specific item that the fee schedule does not address clearly, please contact the Department for further clarification.

3. A ND MAMES provider would like to know why providers are required to submit more & additional documentation...when NDMA is secondary & Medicare primary. Providers are already meeting Medicare's requirements. Does NDMA have additional documentations needs that are more stringent than Medicare? IS NDMA suggesting that the Medicare documentation is not enough, requiring still additional documentation/records as a secondary payer? This is labor intensive and requires extra work, both for the provider and NDMA. Could this process be reviewed?

Response:

NDMA follows our documentation criteria to ensure compliance with Medicaid policies regardless of Primary or Secondary payer source. Please note, should the Department be audited, we need to have documentation to support our decision, regardless if NDMA was the primary or secondary payer source. There has been an increased emphasis on program integrity nationally, and by us asking for the documentation, it protects not only the Department, but the provider as well.

NDMA reviews a 100% of all prior authorization requests. Therefore, your cooperation is greatly appreciated in providing the additional documentation needed in order for the adjudication process to be completed in an efficient manner that meets our policy criteria

4. A ND MAMES provider recently provided a manual wheelchair for a one month rental period. The diagnosis on the prior authorization was "fracture" and a certificate of medical necessity (CMN) was completed, signed & dated by the physician. NDMA requested medical records. This seems extreme in the sense that this claim was for a one month wheelchair rental. The CMN should have been sufficient to explain the medical necessity. Doesn't NDMA have access or ability to review hospital or clinic records that would have resulted from this injury? This is a burden on both the ND MAMES provider and NDMA to gain and review the additional requested documentation, especially on such a small claim.

Response:

NDMA does not have the access to review hospital/clinic records; therefore NDMA must request documentation to support medical necessity.

The UR Team reserves the right to request additional information or deny a prior authorization at any time during the review process.

Additional Discussion:

The new MMIS is scheduled to go live in October 2013. Even with this system, NDMA would not be able to access hospital/clinic medical records. However, with the continued proliferation of electronic health records, access to these records may be an option in the future.

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When NDMA requests/pays for a sleep study, the study is sent for review with that claim, but the document is not retained for later use.

A CMN does not always cover all the criteria necessary and does not replace medical documentation, which is required at times therefore triggering NDMA to request additional supporting documents.

When additional supporting documentation or corrections is requested, the prior authorization is suspended and returned to the Provider. When the prior authorization is resubmitted with requested information or corrections, the prior authorization is processed in the order it is received.

NDMA is open to discussion on how to streamline this process. Currently, the MMIS requires hands on review of prior authorizations to continue to insure the Department's policy criteria are being met.

NDMA will check into the NDHIN exchange as a possibility to electronically submit prior authorizations instead of faxing.

NMDA will develop educational DME criteria for Physicians and publish it on website.

NDMA Notification Protocol

Please define for the ND MAMES providers the NDMA processes of notification & timelines for denials, approvals & additional information requests (for prior approvals). It seems that ND MAMES providers are being notified in a variety of ways. ND MAMES providers want to be sure they are catching all correspondences consistently so that the NDMA beneficiary can be served as efficiently as possible.

ND MAMES Additional Response:

At present time we are receiving faxes and/or paper copies requesting more information for prior approvals. We are not sure why some are faxed and some are sent in the mail. In the past we would always receive yellow sheets in the mail and attached to this yellow sheet was our prior plus a request for additional information. Now we receive these requests by fax and/or mail. The faxes consist of our prior request plus all of the attachments we sent with it. On the bottom of these priors (whether mailed or faxed) will be statements reflecting if it is approved or if they need more information. If the item(s) are approved we get a paper copy in the mail a few days later with the prior number. We would like to know what the proper procedure is so that we know what to expect.

NDMA Response:

NDMA returns all prior authorization requests via fax when illegible, incomplete, or requesting additional documentation. Please remember to use your departments correct fax number which allows us to be more efficient in the return process.

Historically, the formal notification letter is a letter sent to the Provider via mail, not a fax.

These methods of notification are the current and correct process.

Additional Discussion:

NDMA will return only the prior authorization form and the comments sheet when requesting additional items, not all the additional documentation that was originally sent in with the fax.

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Greg Lord asked all providers at the meeting to send him their fax numbers and he will email the list to NDMA.

Electric Beds

A ND MAMES provider stocks only fully electric beds. ND Medical Assistance does not cover fully electric beds. A number of years ago this was discussed with Mary at NDMA and ND MAMES task force explained that ND providers would like to handle this the same way they handle their Medicare customers. ND MAMES providers would continue to provide full electric beds knowing NDMA will only pay for the semi electric. ND MAMES providers are willing to accept the semi-electric bed reimbursement. Can this please be revisited?

Response:

NDMA does not recognize full electric hospital beds as medically necessary. Full electric hospital beds will be reimbursed at the semi-electric standard allowable. See the website for the DME Fee Schedule for allowable costs.

Additional Discussion:

Providers will submit prior authorization for electric beds using the semi-electric bed HCPCS code.

Custom Item Acquisition Costs

A ND MAMES provider recently received prior authorizations back where they provided a custom foam product asking for acquisition costs. Often these products will come in bulk or in big rolls where the provider cuts off a smaller piece and customizes/manufactures the product. It is often extremely difficult to provide NDMA with a specific acquisition cost in these situations. How can this be resolved?

Response:

As previously discussed in the March 2012 DME Task Force meeting, all miscellaneous codes require prior authorization and the invoice indicating the acquisition costs which must also be indicated on the prior authorization. Remember, all discounts (Primary and Secondary) must be extended to Medicaid on these items.

The Department encourages the ND MAMES providers to share current practices and challenges in developing a process to meet the prior authorization requirements.

Additional Discussion:

There was a suggestion made to adopt Medicare's guidelines for labor repairs, for example, wheelchair repairs.

After discussing the possible benefits and drawbacks, the Providers agreed they preferred to continue using the current NDMA accepted method for this process.

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CPAP Coverage

Why does NDMA require ND MAMES providers to provide a documented sleep study? Providers are already completing the prior authorizations and the CMN. Doesn't NDMA have access to these records from the hospital or sleep lab...because NDMA would have paid for these?

Response:

Historically, a sleep study has been part of the policy criteria to be sent with the prior authorization to substantiate medical necessity and must be less than a year old.

NDMA does not have the access to review hospital/clinic records; therefore NDMA must request documentation to support medical necessity.

It is imperative for all appropriate documentation be sent with request for efficient adjudication.

Additional Discussion:

Clarification on documentation must be less than a year old.

Provider example given:

A patient using a continuous positive airway pressure (CPAP) device purchased by Blue Cross Blue Shield (BCBS) 5 years ago is no longer covered by BCBS and the CPAP is not repairable. When submitting a prior authorization for a new CPAP, will the provider be required to submit a new sleep study?

NDMA Response:

A new sleep study will not be required as long as the provider can verify and submit on the prior authorization that there has not been a break in service. A CMN and medical documentation (download) is needed to support compliance. In this example, the trial period would be exempt.

Pulse Oximeters

In the past NDMA has always rented pulse oximeters for children. Most recently they did inquire about purchase. Will NDMA continue to rent the units or will they now wish to purchase from the start? If NDMA is looking to purchase...what will the allowable be?

ND MAMES Additional Response:

"The HCPC for the pulse oximeter is E0445. As a provider, we have always ONLY rented this item to children and have always received rental prior approvals from NDMA. Recently (after requesting a prior for this item) we received a request from NDMA for more information...regarding the purchase instead of a rental. Is NDMA intending to begin purchasing this item? "

NDMA Response:

The DME Provider Manual states all covered equipment may be rented or purchased at the discretion of the Department and is based on the presenting underlying conditions and anticipated length of need.

NDMA fee schedules do have allowable fees set for rental or purchase of an oximeter (E0445).

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Additional Discussion:

Providers will supply rental and purchase cost on prior authorization and NDMA will decide which is the appropriate by using the RR or NU modifier.

Update to Providers concerning RAC and how it relates to DME

The RAC will be reviewing:

- Provider Licensure
- Recipient Eligibility
- National and State Coding Guidelines
- Prior Authorizations
- DME Limits
- Rental vs. Purchase
- Physician Referrals for products
- Documentation

This is not a complete listing, but does give an idea of what will be looked at.

Please note that we look very closely at every type of recovery the RAC suggests. Even though we want to 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, 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.

Dawn Mock - Medicaid Program Integrity Administrator

Larry Stockham - Medicaid Program Integrity Audit Coordinator

Additional Items:

Update on Prior Authorization issues and trends as listed below:

- Place of residence must be current and accurate
- Poor quality and difficult to read. It is of preference to type out a completed prior authorization to increase efficiency.
- Missing or incorrect information :
 - No Provider/Physician signatures
 - Incorrect or missing Provider/Physician number
 - Modifiers on prior authorization and claims
 - Stop dates
 - Invoices
 - Mos. Of rental/Qty. Prescribed

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- 99 months is not appropriate. Need to use 3, 9, or 12 months; unless O2 which needs to indicate 36.
- Labor invoices not itemizing labor units used for each specific item requested.
- Wait 3 weeks before calling provider relations and inquiring on the status of a prior authorization. As the prior authorization may have been adjudicated and entered recently and notification not received yet.
 - 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 more efficient in the return process.
- A requests for adjustment(s) to an existing prior authorization needs to be submitted via fax with an explanation for the adjustment along with the necessary supporting documents. The requests will be processed in the order they are received.

Open Floor Discussion:

The new MMIS is still scheduled to go live in October 2013. NDMA will schedule provider training sessions and consider having additional DME Task Force meetings if needed.

Span Dates:

Erik, Barb K. and Cindy explained that NDMA is working with the Department's NCCI/claim editing vendor, Versik, on how to best correct this issue. It appears that a part of the problem is the claim appears as a duplicate during Verisk's editing process and is being denied. The Providers agreed to submit a list of HCPC codes that mostly commonly been denied to Greg Lord. Greg Lord will email the list to NDMA. Michele A. suggested that providers check the dates of denial on the claims and resubmit if getting close to a year. This will prevent possible denials of claims due to timely filing requirements.

Providers extended an invitation to the NDMA staff for an equipment fair in Bismarck to view items that are being requesting in the prior authorization process. Discussion on possible future dates and location will take place.

NDMA would like THANK ALL OF THE PROVIDERS for their patience and cooperation during this transition time. The Providers are commended for their continued dedication and the service they provide for the NDMA beneficiaries.