

DME Task Force Meeting
9/8/2010

Location: North Dakota State Capital, Judicial Wing, Conference Room D
Attendees: Greg Lord, Kevin Holzer, Steven Jacobchick, Jody Anderson, Gail Urbanec, Pat Greenfield, Jerry Geiger, Kurt Schmidt, Barb Stockert, Cindy Sheldon, Julie Johnson, Dan Johnson, Erik Elkins, Patty Donovan, Mary Helmers

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 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.

Primary Care Physician

1. A ND MAMES Provider says that they are seeing that more & more ND Medical Assistance customers are required to have a PCP. Is there a particular reason for this?

Response: The requirements determining the population required to designate a primary care provider within the Primary Care Case Management Program (PCCM) have not changed. The numbers will fluctuate depending on the population served and continued eligibility.

Discussion: We have over 62,000 recipients right now compared to 58-59,000 recipients last year.

2. What should a ND MAMES Provider do in a situation where a MA Beneficiary is required to have a PCP but end up in the Emergency Room where the attending physician prescribes a piece of equipment? It is probable that the ER physician is not the MA beneficiary's PCP. How should the claim be filed so the ND DMEPOS Provider does not get denied?

Response: North Dakota Medicaid's PCCM Program requires recipients to obtain a referral for any non-emergent visit completed at the Emergency Department. For those visits which are considered "true" emergencies, as deemed by the Emergency Department's attending Physician, they do not require a referral.

For more information, please see the *Payment of Services; Referral requirements for the PCCM program; and Referrals and Prior Authorizations* sections of the *Managed Care* chapter within the *General Information for Providers Manual*. This Manual can be located at the following link:

<http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers-aug2010.pdf>.

Discussion: Hospital admission and surgery require a referral.

N14 Denial

3. A ND MAMES Provider has had some situations where they have received a N14 denial which informs the Provider that the allowable for ND Medical Assistance has been met. But then a few weeks later an additional payment is received NDMA. Can you please explain why this happens?

Response: This is claim specific and should be addressed with Provider Relations.

B18 Denial

4. When a ND MAMES Provider files a claim for an item that is not on the NDMA fee schedule we will receive a B18 denial (i.e., compression stockings). This code informs the Provider that the procedure code & modifier were invalid on that day. Can a Provider collect from the MA Beneficiary when receiving this kind of denial?

Response: The B18 is telling the provider that the code or modifier they are billing with is invalid for those dates of service. There may be a valid CPT/HCPC code or modifier that should be used and the claim resubmitted. The recipient cannot be billed when this denial is received.

Discussion: Example - compression socks are a non-covered item. The provider should be getting a 96 denial code at which time they can bill the recipient. The Provider manual states that a provider can bill a recipient for a non covered item only. Provider can submit an adjustment request indicating that the wrong denial was issued and to issue correct denial.

New NDMA computer system

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

Response: June 2012.

Discussion: No further discussion.

6. When is the estimated date that the system is available to ND MAMES Providers? It would be helpful to know how/when Providers will transition.

Response: Provider Enrollment go-live is December 2011 – Go-live for the rest of the system is June 2012.

Discussion: No further discussion.

7. A ND MAMES Provider has heard that all unpaid claims will be returned to the Provider and will be asked to re-file them? If this is the case, will the filing timeline be lifted?

Response: Claims that are still in suspense at the time of go-live (June 2012) will be denied to be re-billed in the new system. We will put forth our best effort to make sure the backlog of suspended claims is as low as possible before this is done. We will take into consideration any timely filing issues that may result because of this.

Discussion: No further discussion.

8. Once the computer goes live will claims begin processing immediately? A ND MAMES Provider has heard that all payments will be held until it can be verified that everything is flowing through smoothly.

Response: We plan for claims to be processing once we 'go-live' (June 2012) with the new system. However, we cannot plan for unexpected system issues. We will have contingency plans in place to make sure providers still receive payments if the unexpected system issue happens.

Discussion: No further discussion.

9. Will the new system be such where ND MAMES Providers can file records electronically?

Response: Yes, the new system will allow ND MAMES providers to file on-line and have their claims adjudicated in near real-time. ND MAMES providers will also be able to submit their claims via HIPAA compliant 837 transactions. You will also be able to submit prior authorizations on-line.

As a reminder, you can submit claims electronically now (unless documentation is required).

Discussion: No further discussion.

Custom Seating System Allowable

10. ND MAMES Providers discussed the allowable for custom seating systems at the last meeting with NDMA. ND Providers were looking for an increase in payment due to the intensive process in takes to ensure proper fit and support. NDMA's response was: Provide the department with examples of actual payments received from other payers (at least 3) and consideration will be given. The examples are enclosed as "Exhibit A."

Response: We have received and are considering your request; however, no decision is available today.

Discussion: Decision pending.

Wheelchair Transit

11. A ND MAMES Provider had requested consideration of covering "transport tie down bracket." NDMA's response was: This issue will be taken under advisement with the Utilization Review Team, Claims Policy Team and department officials. Since that time a ND MAMES Provider offered NDMA a list of states that currently are covering this option (and those that don't). Roughly

26% of the states responded to the inquiry. Has NDMA made a determination on this product as of yet?

Response: We have received and are considering your request; however, no decision is available today

Discussion: A decision has been made to allow coverage of the Transit option. Maximum reimbursement of \$150 to be allowed.

Standing Frames

12. A MAMES providers asked that the age limit of 2 years be removed from the coverage criteria for standing frames. NDMA removed the age limit but stated that this equipment was for recipients up to the age of 21. A ND MAMES Provider is questioning why a cap of 21 years, as medical necessity remains. NDMA requested case information for individuals over the age of 21 as to why it would be medically necessary. The benefits of standing have already been demonstrated. Research studies on standing frames for adults are attached for review as "Exhibit B."

Response: ND Medicaid has removed the 2 year age limit from the coverage criteria for standing frames. If medically necessary, standing frames are allowed for 0 thru 20 years of age (EPSDT). The recipient must be:

1. In a therapy program established by a physical or occupational therapist,
2. Have a tolerance for standing and partial weight bearing,
3. Unable to stand without the aid of adaptive equipment,
4. The client and/or caregiver demonstrate the capability, and motivation to be compliant in the use of the standing frame.

Over the age of 21 will continue to be a non-covered service.

Discussion: No further discussion.

Prior Authorizations

13. The cost for North Dakota Providers and for NDMA to complete priors for rental items that have coinsurances under \$10.00 is over and above the reimbursement rate. As a rule these items have the same criteria as the primary insurances and are rarely denied on priors. Would it be possible to allow these items to be paid without the completion of a prior authorization? Overall, it would save ND MAMES Providers and NDMA a tremendous amount of time and employee labor costs.

Response: Due to system limitations of the current MMIS system it is necessary to continue to require prior authorization of all rental items.

Discussion: Discussed the new bloodhound system and its capability.

14. Please clarify the requirement of a prior for items \$500 or more. Do items require prior authorization if the *charged* amount is over \$500, **NDMA's allowed amount is over \$500** or if the *coinsurance* amount is over \$500?

Response: **NDMA's allowed amount is over \$500** or the item is identified as always requiring a prior authorization. Reference the on-line DME fee schedule @ <http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/dme/dme-purchase-fee-schedule-eff7-1-2009.pdf>

Discussion: No further discussion.

15. Can the prior authorization (PA) form be updated to allow for more options for patients residence (or place of service?) When the Provider's billing staff are preparing PA's, there is not always a match for the patient's true POS. There are not options for "Assisted Living," "group home," "ISLA-Indep Supportive Living Arrangement," or "MSLA- Minimally Supportive Living Arrangement," etc. These are "types" of residences or care levels that are communicated to us by local referral agencies. The ND MAMES Provider do not want to have to "guess" at which POS type to pick on the prior & risk delaying or denying needed services.

Response: "Other" will be added to the prior authorization as one of the choices for place of residence. The Provider will then identify the TYPE of facility, not the name of the facility, in the blank space that will be provided next to this selection. (FYI: The place of residence on the prior auth is used for adjudication of the prior auth not for claims payment).

Discussion: No further discussion

Lock-in Patient Claims

15. There seems to be some issues in getting lock-in patients' claims paid. Who at NDMA should be contacting when these claims are just not being paid (after months of faxing information and numerous telephone calls)? A ND MAMES Provider was told by the NDMA auditing department to seek out the lock-in department. The lock-in department states they have taken care of it but yet the auditors say it is not and will not pay. Please suggest where to go next.

Response: Galen Hanson, Administrator of SURS, 701-328-4024 or email gehanson@nd.gov. You will need to provide the Name of the recipient, the Medicaid ID Number, the ICN Number and date of service.

Discussion: Galen can be contacted for coding issues, etc...What information can be put in an email? Ok to put phi information since we have secure email. But ok to use just the recipient number and not the name.

Claim Payment Question

16. A ND MAMES Provider has a claim question on NDMA consideration of primary insurance payments. The BCBS's allowable for the K0822 is \$5276.76. BCBS paid \$5263.98 and the remainder of this claim was denied as PR119 which means it is patient responsibility due to yearly benefit had been maximized for the year. In turn the remainder of the K0822 and all of the accessories were turned to NDMA in which a prior was in place. NDMA took the total amount paid

to the K0822 and applied it to E1028, E2365, E2607 and stated primary has paid up to NDMA's allowable. Is this correct?

Example:	Total	BCBS Paid	NDMA Paid
K0822 M51 Powerchair	\$5,454.00	\$5,263.98	\$0.00
E1028 Joystick	\$ 230.00	\$ 0.00	\$0.00
E2365 Batteries	\$ 232.00	\$ 0.00	\$0.00
E2607 Cushion	\$ 356.00	\$ 0.00	\$0.00

Response: This is claim specific and should be addressed with Provider Relations.

Discussion: The provider that submitted this question will need to e-mail the specific claim information to Mary Helmers at mhelmers@nd.gov so further research can take place. Provider is most concerned as to why no payment was made on the e-codes. Consideration would be given based on the situation.

- Technology Procedure Form (905) – Used for new procedures, new technology, medical procedures. Once submitted the request is reviewed with the UR Team as well as Claims Policy for consideration to add to the fee schedule. This form is under e-forms.
- Recent audit on A4554 and A4552: Concerns with claims over the allowed monthly limit with no prior authorization in place. Informed providers that there will be claim adjustments.
- Some concern about prior auths that have been denied and diagnosis codes changes. Need strong documentation for that to take place.
- Providers must use span dates when billing for monthly supplies and monthly rental. Can only bill for 1 month supplies at a time. Providers should not be billing with same date in these situations.
- When priors are submitted with misc codes and invoice is required. An official invoice from the supplier/manufacturer must be supplied. Handwritten or DME provider-manipulated invoices are not allowed. All acquisition costs must be official from the manufacturer. No handwritten acquisition costs are allowed.
- Dispense the most economical and efficacious available to fulfill the basic medical need. Seek voc rehab if the item dispensed is for higher level of functioning for vocational purposes.
- What is PACE? Program for All Inclusive care for the Eldery (managed care program) purpose is to keep people in the community. Pace coordinates all the person's care and provide medical care as well. Tania also administers this program. Pace has been in effect since October 2007. Bismarck has 40 participants with Dickinson at 35. Ours is one of the first rural programs in the nation.
- Senate bill 2167: DME Re-use – A recipient donating their equipment. This bills goal was to make awareness that if a recipient wanted to donate their equipment, they can.

SENATE BILL 2167
Reuse, Recycling, or Resale of Durable Medical Equipment

This bill indicates: —If a state agency uses state funds to provide free medical equipment to an individual, that state agency shall establish a policy addressing the possible reuse, recycling, or resale value of the medical equipment upon replacement of the medical equipment by that state agency or upon disuse of the medical equipment by the individual.

The Department has met with the Durable Medical Equipment suppliers on this change and in the future will be adding information to the Prior Authorization Form. For information on donating, you can contact:

Your Durable Medical Equipment supplier

The State Medicaid Office at 701-328-2321 or 1-800-755-2604

ND Association for the Disabled at 1-500-532-6323 (Leslie)

Project Hero at 1-218-284-6111

North Dakota Development Center at 1-701-352-4501 or 1-800-252-4911 (David R.) or

Easter Seals Goodwill at 1-701-232-1333 (Carol) or 1-701-237-9908 (Cindy)

- Payment error rate measurement (PERM) report per Dawn Mock
- What is the appropriate billing code for Kaye Walkers? It is a reverse walker but not as involved as a gait trainer. Mary Helmers checked with the Kaye Company and at this time it does not have an assigned code. The appropriate code at this time is an E1399. It must be prior authorized and an invoice provided to reflect the acquisition cost.