

SUBJECT: ND MAMES Providers Questions for ND Medical Assistance (NDMA)
DATE: June 17, 2009

In attendance: Brenda Schultz, Jerry Geiger, Barb Stockert, Greg Lord, Kevin Holzer, Russ Nylander, Terry Buetow, Steven Jacobchick

1. Status on Previously Requested Items

What is the status of previously requested items? These include:

A. "Sit to Stand" Standers reimbursement changes.

1. ND MAMES providers are requesting a NDMA reimbursement minimum of \$2,300.00 for these devices plus the accessories. It is not feasible for ND MAMES providers to provide the standers to NDMA beneficiaries for the current payment of \$950.00.

Response: Approval granted Legislative session 2009-2011 and effective 7/1/2009 to increase standing frames (E0637-E0639) to \$2300.00 plus accessories. Accessories will continue at cost plus 20%.

Further Discussion: No further discussion. Providers pleased with the reimbursement increases.

B. Power & Manual Wheelchairs intake/evaluation, preparation/order processing and fabrication/fitting to be included as an addition to the base amount.

1. ND MAMES providers are requesting reimbursement for the intake/evaluation, preparation/order processing and fabrication/fitting to be included in addition to the base amount. ND MAMES providers are requesting \$12.50 per 15 incremental minutes of labor.

Response: Approval granted Legislative session 2009-2011 and effective 7/1/2009 to increase all covered manual and power wheelchair base codes by \$390.00 each.

Further Discussion: No further discussion. Providers pleased with the reimbursement increases.

C. Miscellaneous Codes K0108Request.

1. ND MAMES providers are requesting 35% over product cost plus freight-in (instead of the current 20%) on Miscellaneous Codes K0108.

Response: Approval granted Legislative session 2009-2011 and effective 7/1/2009 to increase K0108 to cost plus 35%. Freight-in will not be allowed. Freight is a business operating expense and not allowed as a separate payment.

Further Discussion: Providers pleased with the reimbursement increase. Clarification provided in regard to cost +35%. This will be applied to miscellaneous code K0108 only. All other miscellaneous codes will remain cost +20%.

2. NDMA Five Year Rule, Disease/Physical Change Progression

Per NDMA policy a wheelchair has an expected lifetime of five years. This is sufficient in most cases for somebody with a non-progressive disease or illness. A person with a progressive

disease such as Multiple Sclerosis can be in a manual wheelchair today and progress to the point where power mobility is needed to be independent in months, a few years later or possibly never need to be placed in a power chair. There is no way of knowing the rate of progression with any disease and should be looked at individually when the initial medical need is established. What does NDMA recommends ND MAMES Providers supply to expedite dispensing new/modified equipment (based on the physician's assessment/prescription for changing equipment)?

Response: 42 CFR Ch. IV 456.3 Statewide surveillance and utilization control program. The Medicaid agency must implement a statewide surveillance and utilization control program that

- a. Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payment;
- b. Assesses the quality of those services;
- c. Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and
- d. Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

NDMA must evaluate whether the new equipment and/or feature(s) meet the recipients medical need that is not met by the recipients current equipment. If the new feature or device meets a current medical need that is not met by the current equipment the 5-year useful lifetime rules do not apply and the new item may be provided. If the new item is meeting the same medical need as the old item but in a more efficient manner or is more convenient, AND there is no change in the beneficiary's condition, NDMA will not reimburse the new item.

Further Discussion: Informed providers of the appeal/reconsideration process as it relates to prior authorization.

Providers are allowed 30 days, from the original denial date, to request reconsideration. Providers must provide additional supporting documentation when requesting reconsideration. If the reconsideration does not prove medical necessity and the original denial is upheld, the recipient is allowed 30 days to appeal from the reconsideration denial date.

Recipients are allowed 30 days, from the original denial date, to request an appeal.

3. NDMA Five Year Rule, Medicare as Primary

CMS Medicare also has a five year rule on medical equipment...but will allow new equipment to be provided if there is a change in the patient's condition and the physician orders the new/modified equipment. If the patient is approved by Medicare, and Medicare is primary (with NDMA secondary) what information that NDMA recommends ND MAMES Providers supply to expedite dispensing new/modified equipment (based on the physician's assessment/prescription for changing equipment)?

Response: NDMA must treat Medicare the same as any other TPL. NDMA may not follow the same coverage criteria as Medicare or other TPL and would therefore require a review by NDMA. Again, the documentation must support a significant change in the client's condition in order for an exception to be considered.

Further Discussion: Discussion of significant change. Consideration is given when NDMA reviews prior authorizations. Stressed again that the change must be significant.

4. NDMA Five Year Rule, Beneficiaries Receiving/Purchasing Equipment

It is a ND MAMES Provider understanding that NDMA has recently established a new rule that if a charitable organization such as the Great American Bike Race or NDAD has purchased a secondary wheelchair for an individual that NDMA considers this equipment the primary wheelchair and a new five year cycle begins over again.

These wheelchairs are given/purchased to/by the NDMA Beneficiary and are non-covered by NDMA, nor any other insurances. These wheelchairs are usually always brought in as a backup for a power wheelchair user that has family that wants to take them on outings and have no way of transporting a power wheelchair or their homes do not accommodate power mobility. Also, by the nature of construction, these wheelchairs are used on a very limited basis and cannot be designated as primary mobility devices. As well, NDMA has no financial responsibility for the payment of these wheelchairs or the cost of maintenance to them.

Are there exceptions to this problem/scenario when the physician prescribes new equipment that he/she deems needed as “primary equipment” during the “second” five year period?

Response: NDMA allows a replacement wheelchair every five years from the date of last wheelchair purchase (manual or electric). If the back up wheelchair is addressed in the evaluation notes, NDMA must take this under consideration.

Clarification on above statement: If a power wheelchair is used outside of the home only, NDMA coverage criteria would not be met. If the manual wheelchair is what is being used in the home the provider should be requesting NDMA coverage for the manual wheelchair and not the power wheelchair.

Further Discussion: NDMA will address this policy with the UR Team and Claims Policy staff.

Providers are concerned that recipients who receive free or donated back up equipment will be penalized when it comes to replacing/repairing their primary equipment. (Example: Manual wheelchair donated by Great American Bike Race to a 5 year old. The manual wheelchair is backup equipment only for community outings. The recipients Power wheelchair (Primary WC) does not fit into the family vehicle to transport).

Claims Policy Outcome: A policy will be drafted in regard to backup wheelchairs.

NDMA will only consider the primary wheelchair when determining the 5 year replacement. The wheelchair evaluation must clearly identify the primary wheelchair used in the home. NDMA will only replace and/or repair the primary wheelchair used in the home.

NDMA has no financial obligation to repair and/or replace a backup wheelchair.

5. NDMA Five Year Rule, Beneficiary Free Care

On occasion families take their children to the Shriners Hospital for Children and come home with new/different equipment. Many times the products are deemed inappropriate for the client by the North Dakota attending physician. The physician may ask the ND MAMES providers to modify or change the equipment. The original Shriner equipment is provided at no charge to these families by people with the “best of intentions”, but Shriner personnel may not have limited access to the most appropriate mobility devices and seating/positioning products. Are there exceptions to this problem/scenario when the physician prescribes modifications or new equipment that he/she deems needed?

Response: This is a problem that needs to be addressed with your professional colleagues. NDMA has limitations that must be followed whether or not it is free care or as you call it inappropriate care. NDMA can not consider replacement of equipment until the useful lifetime limit has been met. In most cases that is five years.

Further Discussion: No further discussion

6. NDMA Prior Authorizations for Labor Related Services

NDMA requires a prior approval to be completed on anything that involves labor. Suppliers can bill out repair parts that are assigned a HCPC code with an established allowable on the Fee Schedule without prior approval but as soon as a labor charge is applied a prior is needed.

This leads to increased wait-time and money for both NDMA and ND MAMES Provider to process the paperwork and in the end the patient is the one that is having to wait for their equipment to be repaired. Many times, ND MAMES members do not bill out labor...just to be sure the patient is taken care of in a timely manner. But this is unfair to the ND MAMES Providers. Is there something ND MAMES Providers can do to expedite a quick repair to NDMA Beneficiaries equipment?

Response: 9/6/06 Minutes:

DME providers had the following concerns:

- a. The time involved to prior authorize for small repairs. Mary indicated that because of concerns from data review, it is necessary at this time to do prior authorization on all repairs. Mary also indicated that even though verbal approvals are not given, agencies could go ahead with emergency repairs (repairs to get the chair mobile) in good faith that the prior sent in would be approved.

Further Discussion: Prior authorization will continue to be required for labor

7. N284 & N286 Denials

A ND MAMES provider has received a number of N284 (Incomplete taxonomy number) and N286 (physician provider number) denials from NDMA.

The NDMA Customer Service Department states that most of these are due to the ND MAMES Provider not listing the ND Medicaid number for that physician.

ND MAMES Providers have been required to use the NPI number for the physician with all other carriers (including Medicare) for some time now...and these other carriers will not accept another identifier. However, ND MAMES Providers are told by NDMA Customer Service that it is the ND MAMES Provider responsibility to investigate these and send in with the correct number because NDMA system does not have this updated information.

Why would this be something that ND MAMES Providers would be required to investigate since it is due to an inefficient NDMA system?

Response: NDMA requires the LU qualifier in situations where a physician/facility has one NPI linked to more than one Medicaid Provider Number on electronic claims.

Further Discussion: Clarification: The LU qualifier is for electronic claims only

8. NDMA Clerical Errors

A ND MAMES Provider has seen an increased number of clerical errors on Prior Authorizations in the last few months. This causes a delay in being able to provide service to the ND Medicaid Beneficiaries. What or how would NDMA like ND MAMES Providers to handle Prior Authorizations that are approved but have clerical errors on them?

Response: Unfortunately with manual entry, keying errors will occur. Providers can refax the prior to the DME Administrator and indicate on the cover sheet the error that needs to be corrected or call the DME Administrator directly and ask the same.

Further Discussion: No further discussion

9. K0739 and K0740 HCPC Codes

Does the NDMA computer system recognize the K0739 and K0740 HCPC codes? Per Medicare the E1340 HCPC code is invalid for any repairs for O2 equipment after 4/1/09.

Response: Yes.

NDMA will also be referencing the Medicare table in regards to units allowed for commonly repaired items. NDMA does not make payment for travel time, pick-up and/or delivery.

Further Discussion: Greg L. volunteered group efforts to assist NDMA in setting repair units for service allowances for commonly repaired items when and if NDMA goes that route. As of today, NDMA will follow the Medicare table.

10. Crossover Claims

A ND MAMES Provider has been receiving numerous denials on many crossover claims, asking for the primary insurance Explanation of Benefits (EOB). The ND MAMES Provider always attaches these to the claim before they are sent. What process is used by NDMA when receiving them? A NDMA employee told a ND MAMES Provider that the EOB's are separated from the claim when they are received (examples can be submitted if you would like). Is this causing the problem?

Response: Any attachments, including the EOB's are scanned with the claim.

Further Discussion: The group was provided the Criteria for Submission of Paper Claims, Adjustment and Attachments.

11. Customer Service "Call-back" Line

Is there a way that the NDMA Customer Service line/process can be updated? Whenever ND MAMES Providers call for claim inquiries we are required to leave a message and the NDMA Customer Service staff will call us back. This takes a lot of time on both ends. All other carriers (including Medicare) allow ND MAMES Providers to talk with their staff at the time, and if research needs to be done...they will do it and call back. Most inquiries can be handled at the time of the call. This would be a huge benefit to ND MAMES Providers and would probably save NDMA time & money.

Response: We do not have the ability to change the process at this time. All calls for Provider Relations are to be left on voicemail.

Further Discussion: No further discussion.

12. Release for Payment, Locked-in

A ND MAMES Provider bills NDMA for home infusion. One patient is receiving antibiotics (pump administered) and one is a hydration patient (pump administered).

Brendan J. has worked with the ND MAMES provider to get the pharmacy component paid. But the ND MAMES Provider is not having any luck getting the DME part paid (currently working with Larry).

The ND MAMES Provider actually started working with Barb C. then Barb G. and now Larry. This problem started in 2006...the beginning of the "S" codes. Larry has told the provider every month that he would get them released for payment.....but that hasn't happened.

The ND MAMES Provider has not been asked for any information or asked to re-file the claims. According to Larry, they should pay. On one of the patients it is hit-and-miss; sometimes the ND MAMES Provider has been paid.

When the ND MAMES Provider called NDMA Provider Relations to get the rest processed, they were told that the claims that were paid "slipped thru" the system and that the patients were still "locked-in."

How does the ND MAMES Provider go about getting paid for these claims?

Response: When the CSP unit receives a call questioning how a claim was adjudicated, there are several possible responses. They are:

1. The claim denied because a referral did not exist from the CSP physician to the providers of services.
2. Notes may be requested to see if the nature of the service is such that it should be payable without a referral or if the CSP physician did indeed refer the client, but the CSP unit did not receive a copy of the referral.
3. The claim contained errors that did not allow for appropriate processing.

It would be necessary for specifics before we can address why these services have been encountering problems since 2006. My last note on claims with 'S' codes was dated March '09 and I thought it was resolved at that time. Apparently that was incorrect. Myself and the CSP unit are willing to assist any provider who feels that a claims was denied in error. It would appear that a phone call from the provider(s) is necessary to resolve this issue. My number 701-328-2334.

Further Discussion: Invited the Provider that submitted the question to please call Larry to resolve this issue. No further discussion.

13. Immediate Services

What would NDMA recommend as proper procedure for dealing with a NDMA Beneficiary who has been prescribed by physicians for supply quantities that are well over the allowed amount? And, the beneficiary needing/demanding the medical supply immediately?

Response: If the provider is confident that the excess quantity would be approved by NDMA, based on the medical need, they could choose to dispense at that time. The provider however, would be taking a risk. If the recipient is demanding the supply before prior authorization is obtained, the recipient would be expected to pay for the item at the time of dispensing.

In rare occasions, and only if the situation is emergent, the provider could call NDMA and ask that a prior authorization be expedited.

Further Discussion: No further discussion.

14. Prior Authorizations

For a ND MAMES member, the process for a NDMA Prior Authorizations takes about four weeks. Should a ND MAMES Provider withhold needed medical items from a beneficiary until they get a Prior Authorization (either an okay by email or the actual Prior Authorization)?

Response: Unless the situation is emergent, providers are encouraged to obtain prior authorization before providing services. If the prior authorization is free of errors and the medical documentation supports the request, providers should be getting the priors back timely.

Further Discussion: No further discussion.

15. Pay for Repair Services

Is there any chance of NDMA changing its warranty repair coverage to mirror that of Medicare? The manufacturer never cover the cost of the labor/service...only the parts. Medicare realizes this and will pay for the labor/service component to repair warranty items. Is there a way NDMA can cover this cost?

Response: If the warranty allows for labor, then labor cannot be billed to NDMA. If the warranty does not allow for labor a prior authorization is required. A copy of the warranty must also be provided with the PA that clearly identifies labor is not covered under the warranty.

Further Discussion: Prior authorization for labor only on warranty items must include a copy of the warranty that clearly identifies labor not covered under warranty or a statement from the manufacturer that clearly indicates they do not have financial obligation to cover labor cost on warranty items.

Additional items discussed:

1. NDMA applauds providers for improving timeliness of prior auth submission. There have been vast improvements made. Many priors are still submitted after dispensing but have been submitted before the 90 day timeframe.
Reminder: Providers who dispense products before authorization is obtained do so at their own risk.
2. Miscellaneous codes require prior authorization. Many priors for misc. items have been denied for no invoice attached. Providers only have 30 days to resubmit the prior along with the invoice for reconsideration. If the prior is not resubmitted with the invoice within 30 days, the provider is liable and not allowed to bill the recipient.
3. Place of residence: Providers are responsible to provide current and up to date recipient information on the prior authorization. Prior authorizations are adjudicated based on this information.
4. As of today (6/15/2009) NDMA will no long update and/or correct recipient information on already adjudication prior authorization.
5. When submitting prior authorization for consideration of continued rental or purchase after the initial 3 month trial period: Providers are asked to submit no less than a 2 month compliance download along with the prior authorization.

6. **Number of units:** In order to be reimbursed correctly, Providers must make sure that they are requesting the appropriate number of units on the prior authorization and/or claim. (Example: A5500- HCPCs Level II Resource Manual identifies this code per shoe. Providers must make sure to request 2 units if dispensing a pair of shoes.)

7. **2009 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."

8. Providers were informed the 2009-2011 Legislative Session passed a bill which will allow Nurse Practitioners to be PCP's. This means, if a recipient has a NP as their PCP, that NP will be allowed to order that recipient medically necessary DME. This will not go into effect by 7/1/09 but rather later in the year.

9. Providers were informed on the current status of the MMIS Project. All questions were asked and answered by Maggie Anderson and Erik Elkins.