



North Dakota Department of Human Services
Division of Medical Services
600 East Boulevard Avenue Dept 325
Bismarck, ND 58505-0250

February 13, 2007

ATTENTION DME PROVIDERS

Please review the information below as it contains valuable information regarding current policy and recent changes to current policy

1. A physician signature/RX is no longer required for repairs to durable medical equipment (DME) that had already been approved as medically necessary. Example: A wheelchair had been approved for a recipient in 2005 and now that wheelchair requires repairs and the wheelchair is no longer under warranty. A prior authorization (PA) is required but a signed prescription from the physician is not. The documentation by the provider will need to support the medical necessity of those repairs.

2. Repair vs. Replacement

Replacement – Component replaced due to normal wear and tear and no labor charges involved. No prior authorization is required if the replacement is not identified on the price file as requiring PA and the cost is less than \$500.

Repair – Component repaired due to damage and requires the provider to bill labor charges. Prior authorization is required due to request for labor.

3. Submitting a PA for repair of equipment:

- a. The PA **must** include repair parts and labor.
- b. If just a labor code is submitted without repair parts, the PA will be denied.
 1. **Exception: Labor only will be accepted for growth adjustments to wheelchairs and standing frames only. Supporting documentation must accompany the PA.**



4. Just a reminder that prior authorization needs to be requested within 90 days from the date of service. If not the PA will be denied and the provider responsible. Items with continuous rental or supplies will have dates of service adjusted to accommodate the ninety-day period. Please see the July 2006 DME manual for this policy.
5. Please refer to the provider price file on the Medicaid website for equipment and supplies that require prior authorization. Prior authorization is required for all items costing \$500 or more, supplies costing \$500 or more per year, rental equipment, miscellaneous charges, and all labor or repair charges.
6. We have received many duplicate PA's with overlapping dates of service. Please keep track of submitted PA's to prevent unnecessary work.

Example: PA faxed today for A4520 with date of service 1/1/07 with a 12 month request, and A4520 already has a prior for date of service 10/1/06 to 9/30/07 with the same provider.

7. HCPC code E1028: If the provider needs to use this code more than once on a PA please use E1028 with total units or you will only be reimbursed for one item. Like codes can only be used once on a PA.
8. Please check the provider DME website often as there will be a new fee schedule released in the near future. New HCPC codes/fees will be included and some HCPC codes will no longer require PA.
9. A new hearing aid policy will be released and posted to the update link in the near future.
10. A certificate of medical necessity is no longer required for wheelchairs. The medical documentation, which is required to accompany the prior authorization, needs to support medical necessity for the wheelchair. The documentation for the wheelchair and all accessories must include the following:



- Is the underlying condition of the recipient reversible and if so what is the length of need?
- An in-home assessment;
- Height and weight;
- When the recipients' last wheelchair had been purchased and the condition of the current wheelchair;
- The recipients' ability, mentally and physically, to safely operate the power wheelchair; and
- Is the recipient home alone during the day and how many hours per day?
- Is the wheelchair for use within the home or primarily for outdoor use? All DME claims are to be submitted initially to the recipients' TPL and then attach the EOB to the claim before submitting to Medicaid.

11. Medicaid stresses the need for providers to check patient eligibility before any product/service is dispensed. Reasons to check the recipients' eligibility are:

- To determine the recipient's name as it appear on the enrollment file. The claim must be filed with the recipient's current file name.
- To check to see if the recipient is eligible on the date of service.
- To check to see if the recipient has a TPL as the claim must be filed to the TPL first
- To prevent the providers unnecessary frustration of working the patient accounts over and over because they are not checking recipient eligibility and they are filing duplicate claims
- Eligibility can be checked by calling the verify number at 328-2891 or 1-800-428-4140



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12. All DME claims are to be submitted initially to the recipients' TPL and then attach the EOB to the claim before submitting to Medicaid.

13. **Services that cover multiple months:**

Due to Eligibility and Recipient Liability, different months, if billed on separate detail lines, must be billed on separate claims.

Example: Recipient receives DME Supplies on Jan 1 and April 1 – These supplies would need to be on separate claims.

14. **Services that cover two months:**

Due to Eligibility and Recipient Liability, do NOT combine two calendar months on one claim. This does not apply to inpatient Hospital claims. Dates of Service cannot overlap.

For example: Service dates are June 17 – September 2; Claim #1 June 17- July 3; Claim #2 July 4 - August 3; Claim #3 August 4 - September 2.

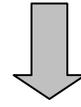
15. Reimbursement for the purchase of DME equipment includes all labor charges involved in the assembly of that equipment, support services such as emergency services, delivery, setup, education, and on-going assistance with the use of that equipment. Maintenance agreements are allowed on oxygen equipment only and not more frequent than once every 6 months.

16. When can a provider bill a Medicaid recipient directly?

In most circumstances, providers may not bill recipients for services covered under 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.
- For a service provided to a Medicaid enrolled recipient after it has been billed to Medicaid.
- 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.
- When services are being provided free to the recipient, Medicaid may not be billed for those services either.



If a provider bills Medicaid and the claim is denied because the recipient is not eligible, the provider may bill the recipient directly.

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.

* If a DME PA is denied with any other reason code than 88, then the service cannot be billed to the recipient.