Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Joint DME Provider Webinar

Health Care Authority (HCA)

Aging & Long-Term Support Administration (ALTSA)

Developmental Disabilities Administration (DDA)

Washington State Health Care Authority

Agenda

- What's Changed and Why?
- Hierarchy of Payers
- Medicaid DME Provider Enrollment Requirements
- Client Eligibility
- Dual Medicare/Medicaid Claims
- Billing Guidance
- Prior Authorization/Limit Extension/Exception to Rule Processes
- Resources
- Question and Answer Opportunity

What's Changed and Why?

Why must DME providers now bill other coverage before being paid by DSHS?

- This rule is not a change; the ability of the payment system to enforce the rule is new.

- HCA and DSHS must follow Federal Medicaid rules. DSHS and waiver programs, in particular, are always the payer of last resort.

Why did SSPS go away?

Centers for Medicare and Medicaid Services (CMS) requires a single state agency to be responsible for administering any Medicaid-funded program or service.

- The Health Care Authority (HCA) is Washington's Medicaid agency.
- ProviderOne is HCA's Medicaid payment system.
- Therefore, HCA's Medicaid program must be given the opportunity to pay first.

Hierarchy of Payers

What is the payer hierarchy?

1. Private Insurance
2. Medicare
3. Medicaid-Apple Health
   - Managed Care Organizations
   - Fee for Service
4. Social Services Programs

Medicaid DME Provider Enrollment Requirements

Provider Eligibility

Medicaid DME Providers must:

- Have a current Core Provider Agreement (CPA) with the HCA or the Managed Care plan
- Be Medicare enrolled
  - This ensures credentialing of DME provider and reduces administrative burden for Medicaid enrollment

See WAC 182-502-0100

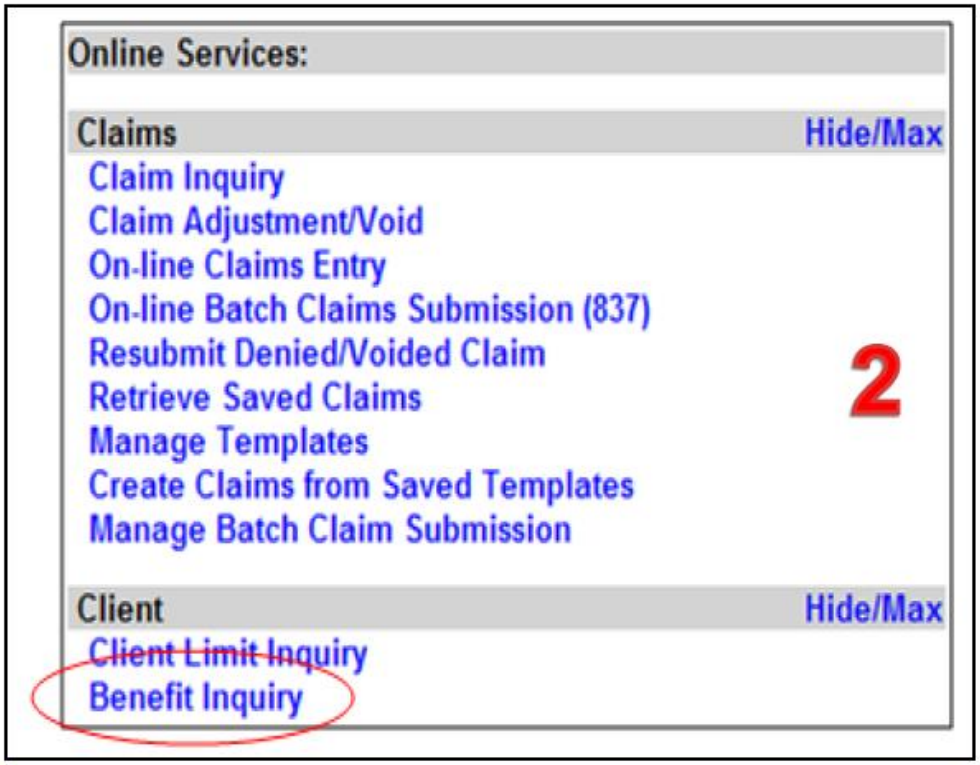
Client Eligibility

Who determines client's coverage eligibility?

DME providers must determine client's coverage eligibility prior to submitting claim.

This is accomplished by reviewing the client's record in ProviderOne. The DME provider will be able to see if the client is enrolled with Medicare or Medicaid: Fee for Service (FFS) or Managed Care

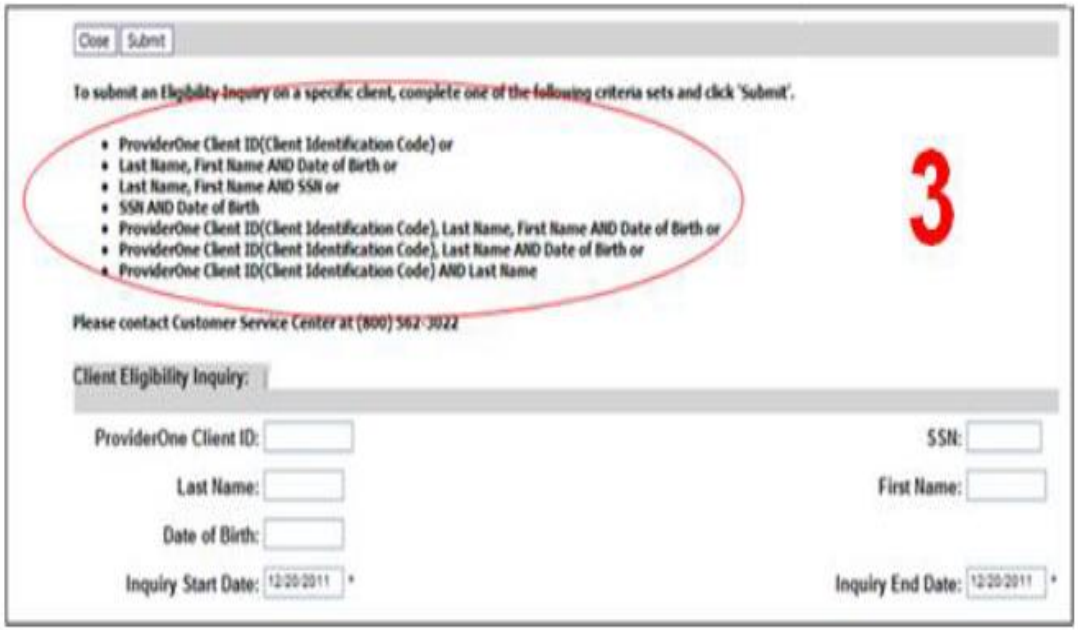
Log into ProviderOne and…



Select "Benefit Inquiry" under the "Client" section of the Provider Portal

Then…

- Use one of the search criteria listed along with the dates of service to verify eligibility.



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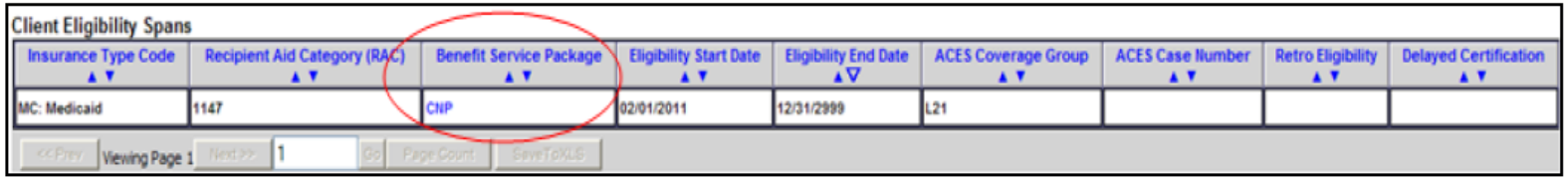
And then…

- After scrolling down the page the first entry is the "**Client Eligibility Spans**" which shows:
  - ✓ The eligibility program (CNP, MNP, etc).
  - ✓ The date span for coverage.



Client Eligibility Spans

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1147	CNP	02/01/2011	12/31/2999	L21			

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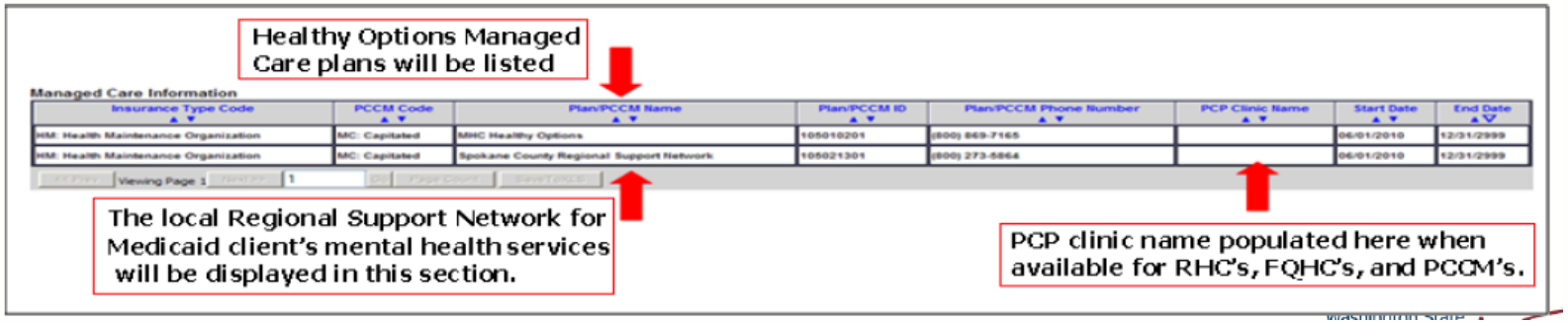
Note: Clicking on the "**CNP**" hyperlink will display the "Benefit Service Package" which is a list of covered services for the client.

"Managed Care Information"



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Billing Guidance

What's changed for DME claims?

The implementation of ProviderOne Phase 2 has brought new functionality to the authorization and claim system that enforces existing federal and state rules and policies.

NEW INFO:

How can a DME provider know a social services authorization will be created?

At any point in this process, a DME provider may submit an invoice to a case worker with documentation that a physician has prescribed an item. Upon receipt of the invoice:

- The case worker can sign and return the invoice to the provider as an indication they are in agreement with the physician that, regardless of whether the item is deemed medically necessary by Medicare or Medicaid, the item is necessary for independent living.
  - Signing the invoice assures the DME provider that should private insurance, Medicare or Medicaid deny the item, a social service authorization will be created.
  - Signing the invoice does not indicate that DSHS agrees to pay the amount on the invoice, only that a social services authorization will be created once all other payors have been exhausted.
  - Case workers are instructed to include with their signature: "***Not to exceed the Medicaid reimbursement rate***". Reimbursing at the Medicaid rate is policy regardless of whether or not it is written on the returned invoice.

What process should a DME provider follow to seek funding through ProviderOne?

- DME providers should follow the same Medicare and Medicaid billing processes that were used prior to implementation of ProviderOne Phase 2 on January 1, 2015
- This includes the fact that all DME requires an order from a health care professional.

Is there a specific form I should use for the order?

Yes. Unless the billing guide directs you to use a specific prescription form for the type of equipment being ordered, you should use HRSA Prescription Form 13-794. (Note: 13-794 is being renamed to HCA Prescription Form)

- Link to Billing Guide (Page 113 refers to necessary forms):

http://www.hca.wa.gov/medicaid/billing/Documents/guides/wheelchairsdmeandsupplies_bi.pdf

- Link to HCA forms page:

http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx

What should the DME Provider do when equipment has been requested without the healthcare provider order?

- Ask the client to obtain one from their healthcare provider.
- Contact the client's healthcare provider.
- The case manager or client's family may be able to assist you with obtaining the contact information.

Do I have to follow the HCA billing procedures to submit a social service claim?

Yes. Providers of medical services and equipment must submit a claim in accordance with:

- CMS, HCA, Managed Care (MCO), ALTSA and DDA rules and policies
- FFS/MCO Provider Notices, and
- FFS/MCO Provider Guides in effect at the time the service or item was provided

Who tells me what code to use?

HCA does not assume responsibility for informing any provider of national coding rules.

Claims billed in conflict with national coding rules will be denied.

Who is responsible for verifying whether the client has medical assistance coverage for the dates of service?

The DME provider is responsible for determining coverage.

See WAC 182-502-0100

A social service authorization has been created but the client has other coverage. What should I tell the case manager?

- Share with the case manager why you think the social service authorization will not pay.
- If the case manager needs more information refer them to their DSHS supervisor.

Will DME providers still receive referrals for equipment from case managers?

- Case managers may be the first to recognize a client's need for equipment and request equipment from a DME provider.
- The DME provider is responsible for obtaining the proper documentation and following proper billing procedure regardless of where the referral originates.

Why does the social service authorization have a status of “Reviewing”?

- The authorization is created with “Reviewing” status so the DME provider can order and deliver the item/service.
- Once the case manager has verified that the item/service has been provided the authorization status will be changed to approved and the claim can be submitted.

Scenario 1

A case manager created a social service authorization but the client has Apple Health, what should I do?

- If prior approval, ETR or limit extension request is needed then follow those processes first and bill Medicaid.
- If Medicaid denies the PA request, bill the claim using the social services authorization.

Do I have to accept the Medicaid State Plan rate even if there is a social service authorization?

- Yes. DME providers may bill the agency using any procedure code connected to the blanket code, up to the maximum amount authorized.
- HCA pays for covered services and items on the fee schedule.
- This is considered payment in full.

What if the Medicaid rate is not sufficient?

- You may not bill the client or social services over and above the Medicaid state rate.
- Submit documentation including the MSRP to the DME mailbox (DME@HCA.wa.gov) with "RATES" in the subject line.

Can a DME provider be paid through ProviderOne for items/services to a client with insurance (other than Medicare or Medicaid) for which the DME provider is not contracted?

No. Please direct questions related to insurance claims to the specific insurance company.

- If a client has third-party insurance which covers an item/service, that insurance benefit is to be exhausted prior to any claims being submitted to Medicare or Medicaid.
- If the client has exhausted their insurance benefit, then claims may be submitted to Medicare and/or Medicaid.

Who "Owns" the prescription and other documents related to the client's DME request?

The prescription from the health care provider and all supporting documentation related to the DME request is the client's property.

Will Medicare and/or Medicaid fund the repairs and maintenance of an item that was originally purchased by an alternative resource?

Yes, Medicare has a process to repair client owned equipment.

The Health Care Authority will review requests for repairs and maintenance on client owned equipment on a case by case basis.

What are non-medical equipment and supplies?

Examples of non-medical equipment and supplies that may be authorized and paid for by DSHS include but are not limited to:

- Reacher
- Sock aid
- Hand held shower head
- Adaptive eating utensils/bowls/plates

How do I get authorized to provide non-medical equipment and supplies?

A DME provider must have:

- A signed DSHS contract, Specialized Equipment & Supplies (template #1062XP-12)
- Provider taxonomy of 33NM00000L for both ALTSA and DDA clients
- A social service authorization using SA420 (Non Medical Supplies) or SA421 (Non Medical Equipment)

Note:

- The DME provider does not have to be enrolled with HCA as a DME provider to obtain this DSHS contract.
- Medical supplies and medical equipment may not be purchased using the Specialized Equipment & Supplies contract.

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Dual Medicare and Medicaid Claims

Do I have to be Medicare enrolled in order to submit equipment claims in ProviderOne?

Yes. Providers of Durable Medical Equipment (DME) and Supplies must be Medicare enrolled.

see WAC 182-502-0100

When I tried to claim on a social service auth my claim was denied because Medicare would cover the payment. How do I get paid?

You need to bill Medicare for the item. If Medicare denies the claim, then you submit the claim in ProviderOne and attach the Medicare denial letter.

What if the Medicare covered item cannot be billed for because the benefit has been exhausted?

- If the client's benefit for the item has been exhausted for the calendar year, the DME provider attaches the documentation from Medicare to the Prior Authorization request.
- If the documentation was received from Medicare earlier in the calendar year there is no need to resubmit claim to Medicare for another denial. You may use this denial to support the exhausted status of the Medicare benefit.

Do all DME items require Medicare denial regardless of whether or not Medicare could fund the item?

No. A denial is not required if:

- The item/service is not covered by Medicare; or
- The client is not covered by Medicare; or
- If the item does not meet Medicare's medical necessity criteria.

Do items statutorily non-covered by Medicare still require denial?

No. DME providers are not required to bill Medicare for Statutorily Excluded Equipment

You can determine what is non-covered through Medicare by using the following website:

https://med.noridianmedicare.com/web/jddme/topics/noncovered-items)

What if the Medicare client needs an upgrade on the DME item but the upgrade is not covered by Medicare?

- Upgrades are not considered medically necessary by HCA and therefore are not covered by Medicaid either.
- Per WAC 182-502-0160(9)(e), clients can be billed for cost of upgrades
  - Provider must keep completed Agreement to Pay for Healthcare Services form #13-879 in client's file for audit purposes. The form can be found at http://www.hca.wa.gov/medicaid/forms/documents/13_879.docx
  - A video is available regarding how to bill a client at http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx#billing

Example 1

Client is eligible through Medicaid for standard walker. However, client requests for the walker to have rear wheels and a folding seat too.

- HCA will not pay for this upgrade request as it is not medically necessary.
- DSHS may pay for this upgrade if the upgrade is necessary for independent living.
- If client agrees to pay for the difference between the standard walker and the walker with the requested upgrades, the DME provider must have a completed 13-879 form in client's file before billing the client.

Example 2

Client's doctor orders a bariatric hospital bed. The DME provider knows Medicare will deny the claim as the client doesn't meet the weight requirement so the provider is not expected to bill Medicare. Therefore, the DME provider submits prior authorization to HCA:

- Use form 13-835. The comments field should state: "Does not meet Medicare MN criteria".
- Also add comment in PA regarding reason that client needs bariatric bed.

HCA reviews PA and:

- approves the authorization for the bed; or
- denies the authorization, in which case DSHS will review the request and may create a social service authorization.

Are we required to obtain Medicare denials for items that do not have HCPC or CPT codes? If so, how do we get a valid Medicare Denial?

No. But even if there are no HCPC or CPT codes, Medicaid may cover the item. A claim may be submitted under DME miscellaneous codes with an accompanying doctor's order and statement describing medical necessity.

- *Questions regarding Medicare coding should be referred to Noridian, which is the Pricing, Coding Analysis, and Coding (PDAC) contractor to CMS.*
- *Noridian can be reached at 1-877-735-1326 or at www.dmepdac.com.*
- *Refer to DME Provider Guide at http://www.hca.wa.gov/medicaid/billing/pages/dme.aspx*

Prior Authorization

Prior Authorization

- When do DME providers request a prior authorization?
  - When directed to do so in the Provider Guide and for all miscellaneous codes
  - Per the indication on the DME fee schedule
  - To request Exception to Rule or Limit Extension
  - When the client's Medicare benefit for the item has been exhausted for the calendar year

What if I think a PA was rejected in error by the HCA?

If you believe that a prior authorization request was rejected by the HCA in error, you can:

- Send the reference number to the DME Mail box (DME@HCA.wa.gov) with “Rejection” in the subject line; or
- Call the DME toll-free line 1-800-562-3022

If a client has Medicare, but the item is not a Medicare covered benefit, is a valid Medicare denial required before submitting to HCA a Prior Authorization, ETR, or Limit Extension,?

No. A Medicare denial is not required if:

- The item/service is not covered by Medicare; or
- The client is not covered by Medicare; or
- The item does not meet Medicare's medical necessity criteria.

Scenario 2

A DME provider has delivered an item with the expectation that Medicare will pay for the item but Medicare denies payment. The item requires prior approval before Medicaid will pay for the item but since the item has already been delivered what should the provider do to obtain payment from Medicaid?

- Submit Medicare denial with the authorization request and required documentation for a Medicaid determination. It will be reviewed post service.

Limit Extension

Limit Extension

- When do DME providers request a limit extension?
  - When a client's Medicaid benefit has been exhausted but the client needs more of an item (e.g. adult diapers)
- How do providers request a limit extension?
  - The process to submit limit extensions is in the Provider Guide. Use the General Information Form 13-835, submit supporting justification of why the item is needed or complete and submit the proper supplemental form from the forms webpage.

Exception to Rule

Exception to Rule (ETR)

- When should the DME provider request an exception to rule?
  - When a client needs a health care item/service identified as typically not covered under Medicaid (e.g., bath equipment)
- How does the provider request an exception to rule?
  - ETRs are submitted as a Prior Authorization with a notation in box 30 of the General Information Form 13-835 indicating that this is an ETR

Form can be found at http://www.hca.wa.gov/medicaid/forms/documents/13_835.doc

What about Non-covered items?

There are some items that are not typically covered by Apple Health which may be covered by social services. Is an ETR to HCA required for these items?

- Yes. Items/services not typically covered by Medicaid require an ETR to be requested and denied before a social service authorization can be created. An example would be bathroom safety equipment (grab bars, basic shower chairs, etc.). In some circumstances this may be approved by Medicaid under ETR.

WAC 182-543-6000 DME and related supplies, medical supplies and related services—Noncovered.

WAC 182-543-6000 lists items that are not typically covered through HCA's medical benefit. Some items that are non-covered items through HCA may be covered through DSHS when there is a documented need. Items not listed in this table are not covered by HCA and also not covered by DSHS (such as hairpieces or wigs and saunas).

Ramps for the home	For eligible clients: authorize environmental modification service codes when modification must occur to a dwelling. Use non-medical service codes to authorize a portable ramp to a vendor who has the Specialized Equipment and Supplies contract.	
Overhead ceiling track lifts	For eligible clients: authorize using environmental modification service codes.	
Personal emergency response systems (PERS)	For eligible clients: authorize using PERS services codes and a contracted PERS vendor	
	Typically Not Covered (Items that may be covered by HCA with an ETR, so a denial is necessary prior to creating a social service authorization)	**Never Covered by Medicaid (No denial necessary prior to creating a social service authorization)**
Bedboards/conversion kits, and blanket lifters (e.g., for feet)		X
Blood Pressure monitoring equipment	X	
Lift chairs		X (Medicare may pay for the mechanical lift portion)
Bathroom equipment used inside or outside of the physical space of a bathroom:		
Bath stools	X	
Bathtub wall rail (grab bars)	X	
Bed pans	X	
Bedside commode chair	X	
Control unit for electronic bowel irrigation/evacuation system		X
Disposable pack for use with electronic bowel system		X
Raised toilet seat	X	
Safety equipment (including but not limited to belt, harness or vest)	X	
Shower chairs	X	
Shower/commode chairs	X	
Standard and heavy duty bath chairs	X	
Toilet rail		X
Transfer bench for tub or toilet	X	
Waterproof mattress covers		X
Surgical stockings, gradient compression stockings, and custom compression garments	ETR -Vendor uses HCA Form 13-871	
Wheelchair gloves		X
Diverter valves and handheld showers for bathtub		X
Adaptive eating/feeding utensils		X
Medication dispensers		X
Clothing guards to protect clothing from dirt, mud, or water thrown up by the wheels of a wheelchair	Covered in PA request	
New DME, supplies, or related technology that HCA has not evaluated	Can be requested to be added (may or may not be covered by DSHS)	

Prior Authorization Process

How do DME providers request a prior authorization?

- Submit required form 13-835:

  1. General Information for Authorization (13-835).
     - Must be typed and serves as the coversheet when faxing in your request to 1-866-668-1214.
     - **Do not use any** other fax coversheet.

  2. Any other additional forms that may be required based on the Provider Guide can be located at the link below:

     http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx

- In addition to the forms above the following information may be required:
  - ✓ The prescription for item/services
  - ✓ An invoice/pricing
  - ✓ Letter of Medical Necessity and/or Charts and justification

How do DME providers request a prior authorization? (cont'd)

Once you have all the information:

- Fax your request (single sided) into the HIPPA Secure ProviderOne fax line at: 866-668-1214

OR

- Mail your request to: Authorization Unit
  PO Box 45535
  Olympia, WA 98504-5535
- When submitting a new request to continue a current services, please submit the request 15-20 days prior to the expiration date of the current authorization end date for continuity of care.

Additional info regarding completion of a prior authorization for DME

For DME requests, in box 30 of the PA request form:

- For clients discharging imminently (within a week) from a hospital or nursing facility, enter "Expedite for Discharge" **and** send an email to DME@HCA.wa.gov with the following on the subject line: "Expedite for D/C"
- For an in-home client who has an immediate need for an item for their health or safety: enter "Home client: safety issues" **and** send an email to DME@HCA.wa.gov with the following on the subject line: "Home client: safety issues" (Use of "Home client: safety issues" will be monitored and if it is overused for situations that are not needed for the immediate safety of our clients, the process is subject to change.)
- For PA requests due to other reasons, enter "DSHS client – ETR"
- When Medicare is primary payer, but client doesn't meet Medicare criteria, enter "Doesn't meet Medicare's MN criteria"

How do I submit additional information to an existing auth when item/service request has been pended?

- There must ALREADY be a request in the system to use instructions on the following slides.
- This is to ADD additional information to a pending request ONLY, NOT to submit a new request.
- If the request has been denied then you do have to submit a new request, these instructions will not apply.

Submitting additional information to an existing authorization…

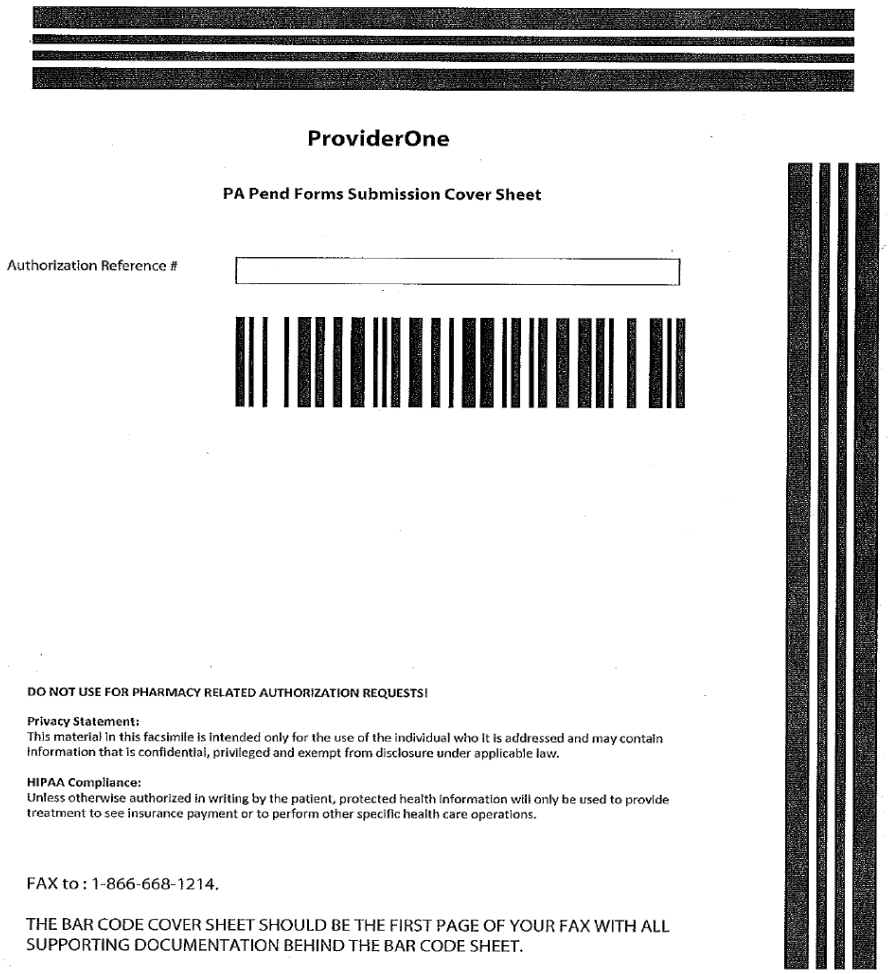
The following form is required: Prior Authorization (PA) Pend Forms

PA Pend Forms Submission Cover Sheet

- Go to ProviderOne Billing and Resource Guide: http://hrsa.dshs.wa.gov/billing/index.html
- Click on "Document Submission Cover Sheets" and then select **"PA (Prior Authorization) Pend Forms** from the options listed.
- Type the 9-digit Reference Number from your Pend letter into the " Authorization Reference# " field and hit Enter. This will expand the bar code shown.
- Click on the "Print Cover Sheet" button; choose "Yes" if you're asked whether you want to allow the document to print, and use the resulting printout for your submission.
- Fax the barcode sheet as the FIRST page (no coversheet) with the supporting documents to 1-866-668-1214 and the documents will be added to this authorization.

For questions between the hours of 9 am -11:45 am, Monday through Friday, please call 1-800-562-3022 then 1, then #, then 3, and dial extension 15466

Example of Pend Form



ProviderOne

PA Pend Forms Submission Cover Sheet

Authorization Reference #

DO NOT USE FOR PHARMACY RELATED AUTHORIZATION REQUESTS!

Privacy Statement:
This material in this facsimile is intended only for the use of the individual who it is addressed and may contain information that is confidential, privileged and exempt from disclosure under applicable law.

HIPAA Compliance:
Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment to see insurance payment or to perform other specific health care operations.

FAX to : 1-866-668-1214.

THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.

01/07/2011 Ver 2.0

Timelines for Prior Authorization Review

- HCA Medicaid has 15 days to review and make decision on PA requests when the request has been submitted legibly with all required documentation. (HCA is committed to completing these within 24 hours.)
- When additional information is needed, request is put into pending status and the DME provider has 30 days to supply requested info to HCA
- Once additional info has been received, HCA has 5 days to review and make decision.

Who is responsible for obtaining documentation for a Prior Authorization, Exception to Rule or Limit Extension?

- The DME provider is responsible for obtaining and submitting supporting information.
- Submitted documentation will be reviewed on a case by case basis to make an authorization determination.

What If a Client Is Enrolled in Managed Care?

The process for providing DME to managed care clients is the same for Medicare and Medicaid fee for service clients.

- The DME provider must:
  - be enrolled with the MCO
  - follow the MCO processes and requirements
  - contact the MCO plan with billing questions

Competitive Bidding

What is Medicare's Competitive Bidding Area (CBA)?

- Vancouver (Clark and part of Skamania Counties)
- Seattle-Tacoma-Bellevue (includes Snohomish County)

To verify if a zip code is within a CBA and to see which providers have been awarded the bids in an area for specific equipment and supplies go to the Medicare Supplier Directory at Medicare.gov.

When can I be paid to provide equipment covered in the competitive bid process to a Medicare client if I am not a competitive bidder?

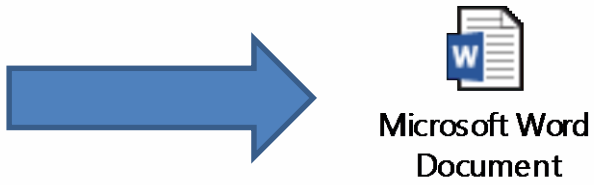
- You can be paid for items not included in the bidding process.
- The only items that must be purchased by the winning bidder through the competitive bidding process for clients with Medicare coverage are:
  - Diabetic testing supplies
  - Ambulatory aids
  - Power wheelchairs
  - Standard manual wheelchairs
  - Negative Pressure wound therapy (VAC)
  - External infusion pumps and supplies
  - Oxygen
  - Hospital beds

Do I need to use encrypted email?

YES!

Anytime client information is included in an email it is the DME provider's responsibility to ensure that correspondence is compliant with HIPAA regulations.

Click here for more information on DSHS' Secure Email System



Resources

- *ProviderOne DME Provider Billing Guide*
- WAC 182-500-0070 Medically Necessary
- Important Message About DME Denials
- FAQs for DME Providers

Question and Answer Session

Q&A

Q: So if non-medical supplies and equipment SA420 and SA421, and even lift chairs SA419 are not yet in the system, when will you start looking at social service billing with these codes? How are these to be authorized now?

A: All of these codes are in the system. SA420 and SA421 have been in the system since we went live on January 1, 2015. SA419 has been in the system for the past several weeks, and staff have been being informed of this code and how to use it.

Q: Will DSHS pay authorizations when Medicare denials have included the GY modifier (which indicates the item is statutorily excluded), which is an admission by the supplier that the item does not meet medical necessity requirements? Does Medicaid ever pay if Medicare criteria is not met?

A: This modifier is used to obtain a denial on a non-covered service. The use of this modifier is to notify Medicare that you know this service is excluded. Medicaid does not recognize this modifier.

Q&A

Q: Do we need to submit an ETR to Medicaid for never covered items like reachers and sock aids which have never been a covered item?

A: No. For items on the never covered items list, no ETR is necessary.

Q: If social services authorizations will plummet because of the requirement to bill primary payors first, are SSA training and processes now moot? Is it correct to say the social service authorization is now only for the last 5-10% who do not qualify otherwise?

A: Both are incorrect statements. Social services had, in the past, been paying for many items that met medical necessity criteria and would have been paid through Medicare/Medicaid had they been billed. We are simply saying that when a client's DME needs meet medical necessity criteria, they will now receive the item through their medical benefit instead of a social service benefit. Any items never covered such as mattress covers or hand held showers will continue to be provided to clients who need them to live independently, regardless of medical coverage.

Q&A

Q: Is it possible to have items added to the list of statutorily non covered items? For example.... syringes are never covered by Medicare under a DME benefit but the denial is currently still required.

A: We will need specific code as Syringes are covered and located in the Medical Supplies and Equipment Provider Guide(MSE). Specific code question can be sent to DME MAILBOX

Q&A

Q: Who should provide the DME suppliers the prescription? The DME provider can't contact the MD to initiate an order because it is viewed as soliciting so the client must contact the MD for a RX for equipment needs.

A: The client must pursue getting the prescription from the medical provider. Family members can assist or the case worker. Once the DME supplier gets the Rx, the DME supplier can follow up with the MD for missing information on the Rx.

Q: What will be the process for repairs on equipment purchased and paid by SSPS from the past (since the insurance does not have anything on file for said equipment)? Will there even be a repair payment process allowed on the equipment?

A: Repairs will be reviewed case by case. It is very helpful to submit all known information. Repairs can be called in to the DME Authorization line if there are 5 lines or less.

Q&A

Q: For shower chairs and blood pressure machines, we know that it is not covered by either Medicare or Medicaid and we used to get payment directly from SSPS. How do we go about getting paid for these types of items now?
A: Shower chairs and blood pressure monitors are both not typically covered items and will require an ETR to see if the client meets the MN criteria prior to a social service authorization being created.

Q: You said a DME provider could send an invoice to a case worker with documentation of the physician's prescription and that if they sign it and return it, that is a verification that the case worker will create the social services authorization if all other payor sources deny. Is it also a guarantee that they will reimburse at the rate on the invoice?
A: No. It only indicates a social services authorization will be created.

Q&A

Q: Are DSHS staff being provided this information?

A: Yes. The Management Bulletin is being revised and two webinars were held with staff. Over 500 staff from Home and Community Services, Area Agencies on Aging and Developmental Disability Administration participated.

Q: If a patient has Molina and we bill and get the denial, how do I bill do get paid under a social service auth?

A: Same process as with a Medicaid Denial, provide the Denial to Case Manager to have a social services authorization created (if the item is determined to be necessary for independent living).

Q&A

Q: Is the HRSA Form required for items billed to social service, even when it is a non covered item with Medicaid and Medicare?
A: The Medicaid (HCA) prescription form is not required; but all items requested do need a prescription to process.

Q: I have a couple patients using catheters and have had an additional quantity paid for by Copes. Would we bill for the entire quantity on a single line? Is there a modifier that should be applied?
A: Has a Medicaid Limit Extension been requested? Each Code has it's own line. If you have a specific question regarding a code, please send to DME mail box.

Q&A

Q: Should we bill on a UB or HCFA-1500 claim form? What claim form is acceptable to bill the item?

A: HCA prefers electronic billing.

Q: To bill for an item, what claim form is acceptable if we bill electronically?

A: There are no forms for electronic billing

Q Is it true that for us to bill Social Service programs, we must be contracted and able to bill the patient's Medicaid managed care organization (MCO)? So if we're not contracted with that plan, we cannot bill Social Services?

A: No, if you are not contracted you cannot bill the MCO. If a denial of benefit from the MCO can not be documented, the case worker cannot create a social service authorization for the item.

Q&A

Q: Can you please confirm that all orders that we have supplied to July 10, 2015, that were approved by case managers, will be paid?

A: All orders that were supplied prior to July 10, 2015 that are on the typically not covered list will be paid for without the necessary denials. DME providers will not need to do anything differently to bill these claims.

Q: For social service authorizations, is the expectation that the case manager issue an auth prior to a provider delivering the item?

A: Yes. The authorization will be in "Reviewing" status until it is confirmed that the client received the item. After verification is received, the case worker will change the status to "Approved" and the DME provider will be able to claim. If a DME provider wants assurance a social services authorization will be created, they can provide the case worker an invoice for the item with documentation of a prescription. A signed, returned invoice is assurance that the case worker agrees that the item is necessary for independent living, but it is not a agreement for a rate.

Q&A

Q: What about MCO's that are not accepting new providers?
A: MCOs have a network adequacy requirement they must meet which ensures enough providers in their coverage area. They are not obligated to contract with every vendor if this requirement is met.

Q: What are clients supposed to do when they have a private insurance but they can't find a DME company that accepts DSHS that is contracted with the insurance? I believe this is going to be a problem for wheelchairs with clients having Medicare primary.
A: A vendor that accepts Medicare is all that is necessary to obtain a wheelchair that will be paid for through Medicare. A social service authorization would not need to be created.

Q&A

Q: In the past I have been told that we must first bill Medicare for denial of a statutorily excluded item, then appeal that denial, and THEN submit to DSHS for payment. Has that changed now? For example L3030 foot orthotics might be covered by DSHS but they would not be covered by Medicare. So we just bill DSHS directly if the patient qualifies for these orthotics and/or obtain the DSHS authorization?

A: List Medicare info in Box 30.

Q&A

Q: As of today many DME providers are not Medicare Accredited as required. Is HCA going to enforce this rule?

A: Yes.

Q: If a medical product does not have a HCPC code are we required to submit for ETR?

A: All items requested under miscellaneous code require Prior Authorization.

Q: How do we use the same and similar function in P1?

A: Benefit Inquiry (Same Similar):

http://www.hca.wa.gov/medicaid/provider/documents/clientbenefitlimitinquiry2014.pdf

Q&A

Q: I cannot find WAC 182-502-0160(8)(e) - 182-502-0160(8) only appears to have sections (a) through (c) and they concern refunding clients. Can you help?

A: WAC references have been corrected in this presentation.

Q: Will you please clarify the SA626 code?

A: SA626 is used for installation and maintenance of equipment. It may also be used if a DME provider is authorized to assemble/disassemble DME that is being moved by an authorized, contracted mover.

Q: You noted that the case manager can be helpful in obtaining info for ETR. Can we complete that data on the ETR form and let the MD know that info was from CM and ask if they concur to sign?

A: The client/ family/NSA (with the assistance of the case worker) should work with the physician.

Q: Is A9270 being added to the Blanket Code List and if it is, under which category is it being added?

A: A9270 is not being added to the blanket code list. If a social service authorization is warranted, A9270 is the code to be authorized.

Q&A

Q: This is going to increase denials rates for us. How can we know that it will not be used against us, as Medicare did announce that they can remove a provider for high denials?

A: Vendors do not have to bill Medicare for non-covered items.

Q: Are we able to use that email address to check status on prior authorization requests? We have a really hard time getting through on the phone during the allowed time frame.

A: Vendors can check Provider One for status checks. There is no guarantee for responses.

Q: Some of the information regarding ETRs contradicts information we received through HCA's list serve. Which is correct?

A: This presentation is correct.

Q&A

Q: If a customer comes in to the store and has Medicare and DSHS and does not qualify for the item thru Medicare then we would have them sign a ABN and would collect money upfront from the customer. Without an auth # from the case manager then should we be collecting money from the client?
A: No. You should submit an invoice to the case manager along with documentation of the prescription. A signature from the case worker is an assurance that a social services authorization will be created (and reimbursed at the Medicaid reimbursement rate).

Q: If an item does not have a blanket code and must be billed under a misc. billing code, does it still need prior authorization through HCA before being paid? Or is this an item that can be paid by social services?
A: It depends. A typically not covered item will need an ETR. A never covered item will not.

Q&A

Q: I'm looking at the ETR request form for bathroom equipment. There are questions about being unique, what other less costly alternatives etc. Some item are basic products that are not unique and ARE the less costly alternative which and they can be found in stores like Home Depot or Walmart. It is true HCA doesn't pay for items available in a retail store?

A: This is not true. You must follow ETR process for bathroom equipment

Q: For bathroom equipment, take for example a raised toilet seat, is a DX of Hip replacement on a HRSA RX sufficient or are chart notes still required when submitting an authorization request?

A: You must use current information; the physician must complete ETR for bathroom Equipment.

Q: Do I need to request an ETR for a shower head?

A: No. Shower heads are on the never covered list. No ETR required.

Q&A

Q: What about lift chairs?

A: DME vendors are now billing separately the two components which make up a lift chair. Those components are: 1) the lift mechanism/motor portion; and 2) the furniture portion.

1. Lift mechanism/motor portion:
    - Clients who are enrolled in Medicare who meet Medicare's criteria for medical necessity will have the lift mechanism/motor portion covered under their Medicare benefit.
    - If a client's case worker determines that a lift chair is necessary for independent living, DSHS will pay for the lift mechanism/motor portion for:
        - Clients not enrolled in Medicare.
        - Medicare-enrolled clients after Medicare has denied the vendor's claim due to the client not meeting the medical necessity criteria.
2. Furniture portion:
    - The furniture portion is never covered by Medicare.
    - DSHS will cover the furniture portion of the lift chair if the case worker has determined the lift chair is necessary for independent living.

Q&A

More about lift chairs…

The two codes together will pay for the entirety of the lift chair; one code on its own is not sufficient. Please see the Service Code Data Sheet for SA419 for more information.

The new process is:

Medicare only (Client is enrolled in Medicare or is dually eligible):

1. The vendor can submit claim to Medicare for the lift mechanism/motor.
2. If Medicare pays for the lift mechanism/motor: authorize SA419 (Lift Chairs Furniture portion only) for the balance remaining on the price of lift chair.
3. If Medicare denies payment: authorize SA879 for lift mechanism/motor portion. The vendor may now claim through P1.
4. After the vendor has been paid for the lift mechanism/motor, authorize SA419 for the balance remaining on the price of lift chair.

Non-Medicare only:

1. Authorize SA879 for lift mechanism/motor portion. The vendor may now claim through P1.
2. After the vendor has been paid for the lift mechanism/motor, authorize SA419 for the balance remaining on the price of lift chair.

Q&A

Q: Medicare only pays 80% of the allowable charges for any DME item. The remaining 20% is the coinsurance amount. Medicaid routinely denies that coinsurance amount as Lift Mechanism is not covered by Medicaid. Are you saying that SA419 will only cover the furniture portion of the chair, or will it also cover the 20% coinsurance on the lift mechanism that Medicaid denies?

A: Medicaid only pays up to our allowed rate; since we use Medicaid rates there is nothing left for Medicaid to pay.

Q&A

Q: If a client has Medicare and Medicaid and we supply equipment that is non-covered by Medicare but we have to bill them for the denial, do we also have to bill Medicaid even though they usually follow suit with Medicare?

A: Yes, if the item is covered or typically not covered. If the item is never covered (see list in this presentation), a Medicaid denial is not necessary.

Q: Are bathroom equipment on the blanket code list?

A: Yes. Blanket code SA875 is the blanket code for most bathroom equipment.

Q&A

Q: Is there going to be diagnosis driven policy for bathroom equipment because I believe that the prior auth requests are going to overwhelm the department with most of those requests being denied with this be a waste our resources and HCA?
A: This is a good idea. We will explore options.

Q: Do the case managers know that repairs should now have the SA626 code?
A: The correct detail code for repairs or service to non-oxygen DME is K0739. This code is not contained within a blanket code; it is authorized directly on a social service authorization (assuming a social service authorization is warranted).

Q: In order for DSHS to pay an authorization, do denials from Medicare or Medicaid need to be denials to Patient Responsibility, or can they be denials to Contractual Obligation?
A: You can use Box 30 and note Contractual Obligation.

Q&A

Q: I'm confused; is the ETR process being used for the decision on needing something for independent living? Or is this for the Case Manager to decide?

A: When referencing an ETR, it is HCA's process to determine medical necessity for an item typically not covered. If the ETR request is denied, the case worker, based on information from assessments, case notes, etc. to decide if the item is needed for independent living.

Q: Please explain the review process and documentation required for HCPCs listed as By-Report on the fee schedule, i.e., A9276.

A: "By report" codes will need PA and vendor must submit MSRP or invoice for payment.

Q&A

Q: How is HCA going to handle the changes to the national coding for 2016 and the removal of the HCPC code E1399 and K0108?

A: There has been no decision at this time.

Q: Client has Medicare/Medicaid. We bill Medicare for an item expecting them to pay, but they deny the item. Previously it has been said that at that time we can submit a request to Medicaid to get approval. Will they accept the RX and medical documentation we have on file? Medicare requires their own specific RX and medical documentation not on Medicaid forms. We would not have had the Medicaid forms completed since we expected Medicare to pay.

A: Yes; these are handled reviewing for medical necessity.

Q&A

Q: Did I hear right when billing SA420 and SA421 we would not need prescriptions? Also pertaining to those codes, I thought I heard there would not be detail codes attached to them. Will you be giving us instructions on how to upload into ProviderOne without a detail code, diagnosis or doctor info?

A: Unlike claims for medical codes, claims for strictly social service codes (such as SA420 and SA421) are input into the ProviderOne Social Service Portal. This is a different (but similar) portal than the claims you submit for medical services. Social service codes are locally-created detail codes in and of themselves; there are no HCPCS or CPT detail codes lying behind them. Claiming for social services does not require any additional detail codes, diagnosis codes, prescriptions, doctor info, Prior Authorization/Exception To Rule/Limit Extensions, etc.

Your company will need to get a Specialized Equipment & Supplies contract with DSHS. Once this contract is in Signed status, ProviderOne will be updated with your additional taxonomy (33NM00000L Non-medical Equipment/Supplies) and the Provider Enrollment unit will contact you with information on how to log into the Social Service Portal.

Q&A

Q: Is there training available for billing through the social services portal?
A: Yes. Go to https://fortress.wa.gov/dshs/adsaapps/providerone/ for comprehensive training.

Q: Is there training available for the medical portal?
A: Yes. Go to http://www.hca.wa.gov/medicaid/provider/Pages/index.aspx

Q: What do we do if the MD does not fill out and return the ETR requests? This is already a problem with Medicaid items requiring prior authorization that ARE medically necessary…
A: The client/family member/ representative (with assistance from the case worker) can follow up the physician.

Q: What if a patient gets an item in January but Medicare does not make a decision until March and the patient is no longer on service with social service?
A: Social services will pay for items for the period of time the client was on services.

Q&A

Q: Who do we contact go get the Specialized Equipment & Supplies contract?

A: The Specialized Equipment & Supplies contract (#1062) is available through the contracts manager at your local Area Agency on Aging. You can find their information here:

http://www.agingwashington.org/local-area-agencies-on-aging/

Q: Just to clarify, to provide items that are covered under a non-medical equipment and supplies service code, we will need an additional contract and taxonomy code to bill these items. If we were to bill these items with a DME Taxonomy will the claim deny for provider type?

A: Yes.

Q&A

Q: When will the Social Service blanket code spreadsheet be updated to reflect more national codes?

A: We agree the table is outdated. We are hoping to have it updated soon. However, just because the table posted has not updated does not mean that new HCPCS codes have not been added to the blanket codes.

Q: Will the provider guide be updated for bundling services according to the national corrected coding initiative?

A: Yes.

Q: How long will the BASS unit be available?

A: The BASS unit will be available until you hear differently.

Q&A

Q: Is the COPES program going away?

A: COPES is a single program within a larger social service system. We have many programs that purchase DME. Social service authorizations (including through COPES) are not going away but will continue to help meet our client's needs for items necessary for independent living.

Q: How do we bill non-DME that used to be authorized through COPES, like anti-skin breakdown creams and lotions? There are no HCPCS codes to bill these to Medicaid.

A: This is not a covered service with Medicaid.

Q&A

Q: What about PERS units?

A: Do be able to provide PERS units, you must have a contract with DSHS to provide PERS services.

Q: Do the electronic medication dispensers fall under the same category as the PERS units?

A: If an electronic medication dispenser is part of a PERS unit, you must have a contract with DSHS to provide the service. If it is not, you need the Specialized Equipment and Supplies contract.

Q&A

Q: We have never heard this process exists. Isn't it overly optimistic to expect a 1 day turnaround?

A: All requests have a 15 day turn around per WAC. While there has always been an expedited process in place to request DME, the DME@hca.wa.gov mailbox is new. The email notification was added to provided additional communication.

In an effort to be sensitive to the client's needs being met thru this transition, there has been a 1 day turn around for ETR decisions since July 11, 2015.

Don’t forget…

The email response box has been provided to submit questions directly to the experts at HCA. It is available to vendors and DSHS staff when there are questions:

- DME mailbox address: DME@HCA.WA.GOV
- Suggested subject lines:
  - Expedite for D/C (for d/c within 1 week)
  - Home client: safety concerns
  - Rates Request (if the vendor says the rate doesn’t cover the cost of the item.
  - When Medicare is primary payer, but client doesn’t meet Medicare medically necessary criteria, enter “Doesn’t meet Medicare’s MN criteria”

For More Information

- Email DME@HCA.WA.GOV
- Call 1-800-562-3022