Transforming Lives

Authorizing Shared Medical Services

Emphasis on DME

Payment Hierarchy

Understanding MB H15-035

- Providers are required to bill other payment sources before claiming payment through Apple Health or a social service authorization.
- Providers must not request additional payment through a Social Services Authorization or private funds if they feel the Medicare or Apple Health rate is too low.
- A Social Services Authorization must not be created solely because the vendor says the medical reimbursement rate is too low.
- The implementation of ProviderOne Phase 2 has brought new functionality for authorizations and claims and enforces these existing rules and policies.

Understanding MB H15-035

- IMPORTANT NOTE:

- There are some revisions to procedures that were provided in the MB. Clarifications will be called out during today's presentation. The MB will be updated soon.
- There are two types of "non-covered" items included in HCA WAC:

a) Durable medical equipment and supplies (e.g. transfer benches, bath equipment including grab bars, shower benches and commodes, etc.). For our purposes, we will refer to these as "typically not covered".

b) Non-medical equipment and supplies (e.g. reachers, sock aids, handheld shower). We will refer to these items as "never covered" items.

Understanding MB H15-035

- DSHS and waiver programs are always the payer of last resort.
  - Private insurance, Medicare, Apple Health (Medicaid) or other available coverage must be used prior to a social service authorization.

- Case workers are required to ensure other available coverage is utilized prior to completing authorizations to providers. A cheat sheet on determining medical coverage in ProviderOne is attached in the MB.

Did you know?

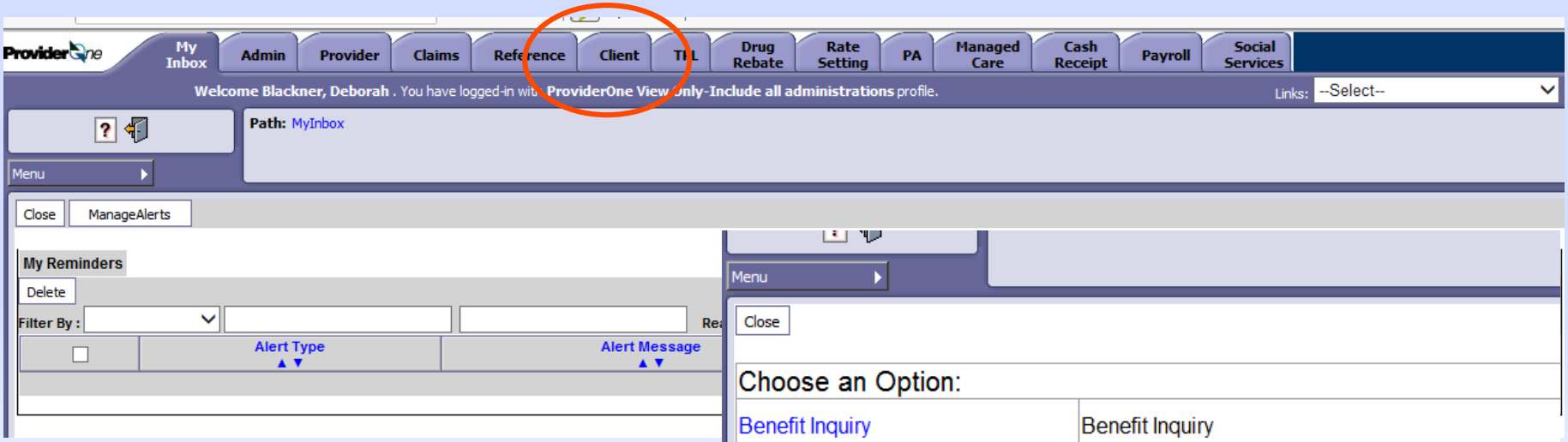
At any point in this process, a DME provider may submit an invoice to a case worker with documentation that a physician has prescribed an item. Upon receipt of the invoice:

- 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.
- If signing the invoice, the case worker must include the statement “Not to exceed the Medicaid reimbursement rate” with their signature.
  - 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.
  - The provider will be paid at the Medicaid reimbursement rate or the authorized rate, whichever is lower.

Determining Medical Coverage

How do I know what medical coverage a client has?

1. After signing into ProviderOne, click on the **Client** tab

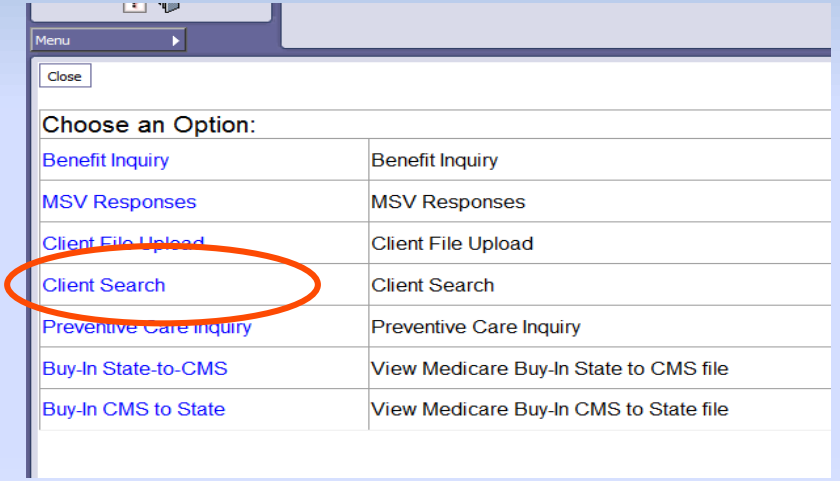


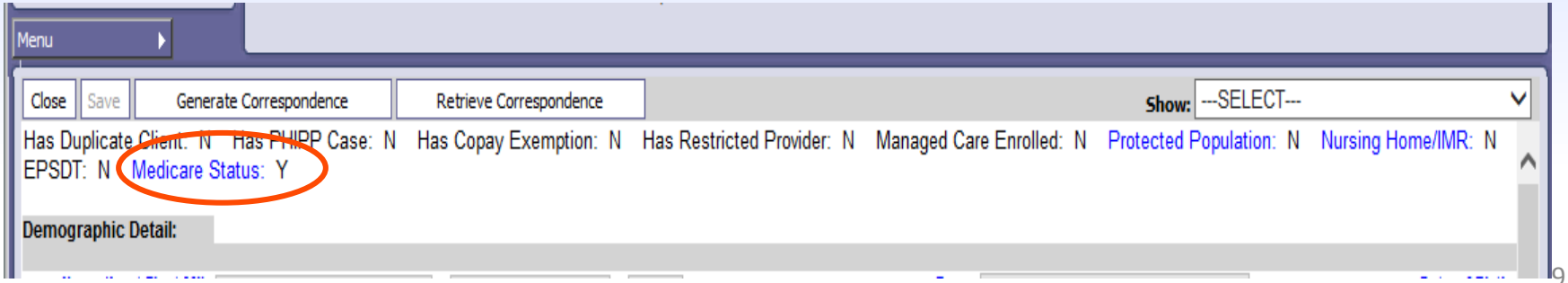
2. What you click next depends on what you want to verify.

How do I know what medical coverage a client has?

To determine if the client has MEDICARE:

- Search for the client using Client Search
- On the Demographic Detail tab, look for a Y (Yes) or N (No) next to Medicare Status

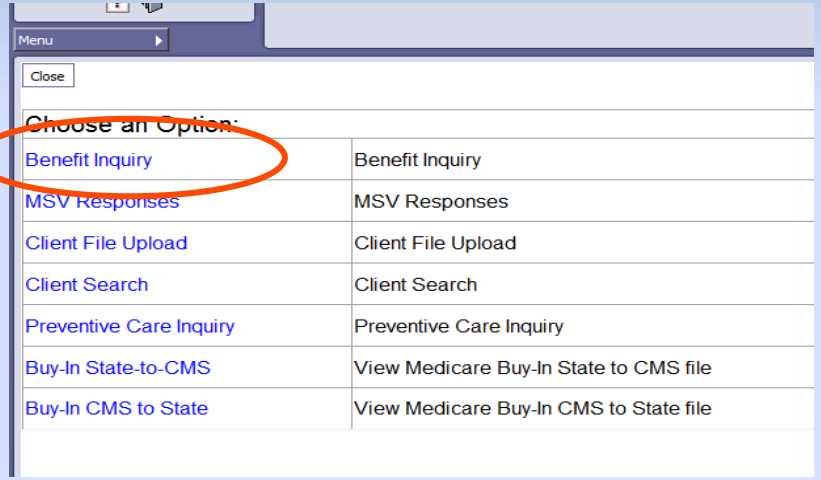


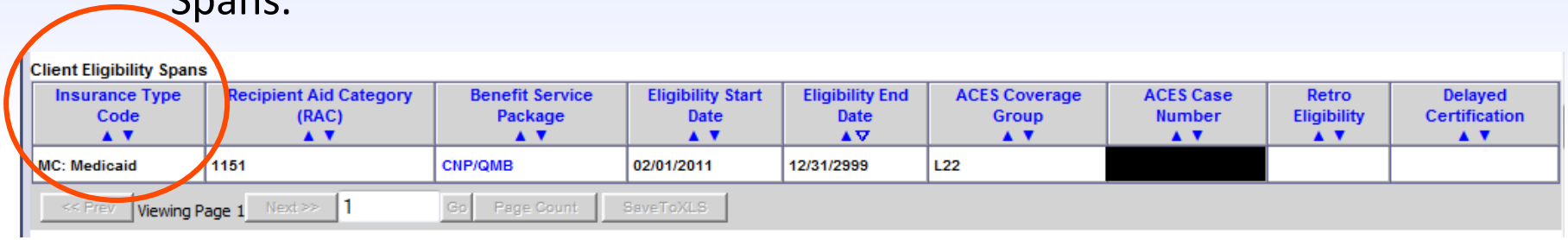


How do I know what medical coverage a client has?

To determine if the client has MEDICAID:

- Go to the Benefit Inquiry page
- Search for the Client based on eligibility dates
- Choose “30-Health Benefit Plan Coverage” from the Service Type Code drop down.
- Click Submit at the top of the page
- Scroll down to “Client Eligibility Spans.”

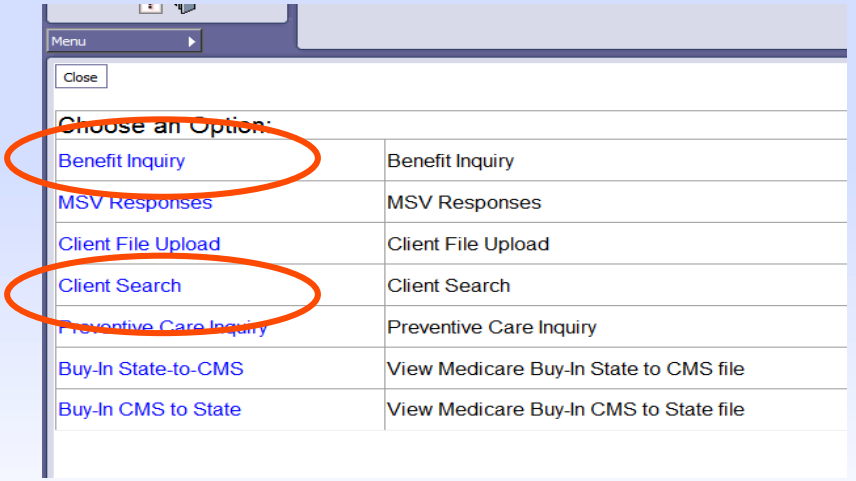




How do I know what medical coverage a client has?

To determine if a client is dually eligible (both Medicare and Medicaid):

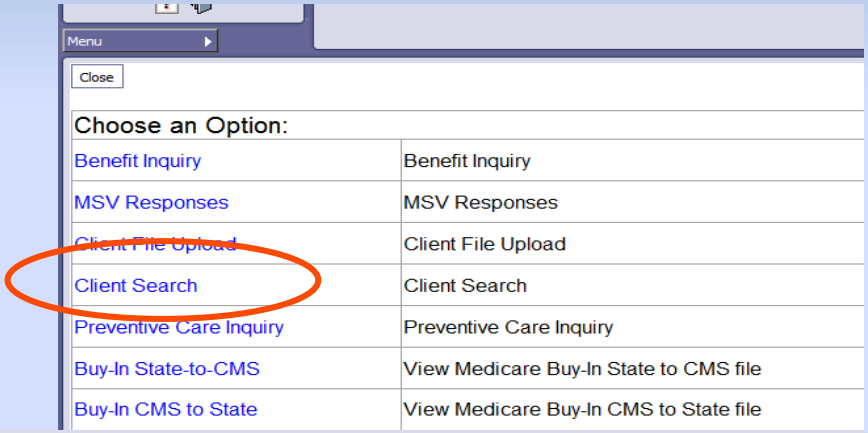
- *If eligible for Medicare* **and** *either CN or MN Medicaid (see previous slides), the person is a dual eligible.*
- ***Note** – a Medicare Savings Program only (S03, S04, S05, or S06) means a person does not have CN or MN Medicaid.*

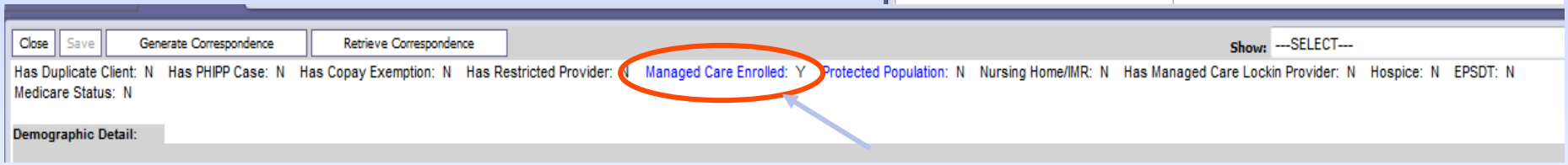


How do I know what medical coverage a client has?

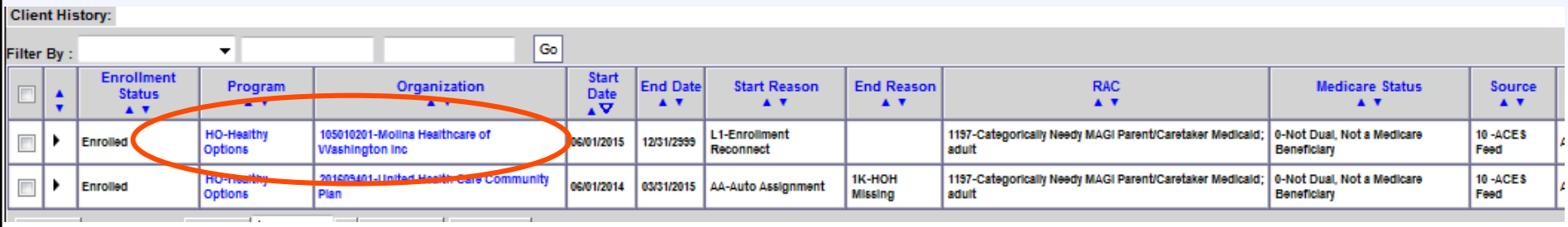
To determine if a client is enrolled in Managed Care:

- On the Client Demographic screen in ProviderOne, look for a Y (yes) or N (no) next to Managed Care Enrolled





When marked Yes, clicking on the hyperlink "Managed Care Enrolled" will show you what plan the client is enrolled in:

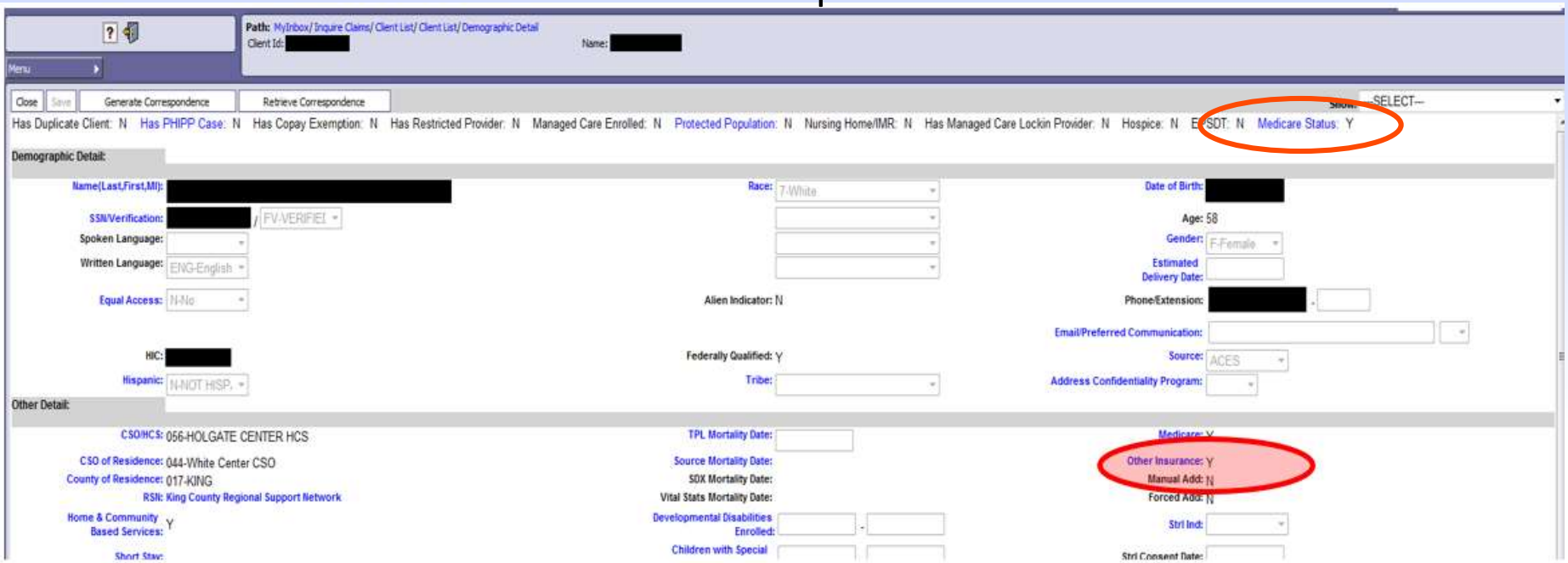


How do I know what medical coverage a client has?

To determine if a client has a private insurance (third party liability):

- On the Other Detail section of the Demographic screen in ProviderOne, look for a Y (Yes) or N (No) next to Other Insurance.

- The client below has both Medicare and private insurance.



FAQS

Q: Does the case worker do anything different if the client is enrolled in an Apple Health managed care plan?

A: If the client is enrolled in an Apple Health managed care plan, the case worker should not create an authorization in ProviderOne. The DME vendor should work directly with the managed care organization (MCO) to obtain the necessary equipment. The DME vendor must be contracted with the client's MCO to be able to fill the authorization.

Q: What do we do if the MCO is not meeting our clients' DME needs?
A: If there are problems with the MCO not meeting the DME needs for clients, email DME@HCA.wa.gov.

FAQS

Q: Why should I look this information up in ProviderOne? Doesn't ACES tell me the same thing?

A: We encourage staff to use ProviderOne. The more case workers use ProviderOne, the more comfortable they will get at it.

Q: Is there any training available on how to navigate ProviderOne?

A: There is training available at http://intra.altsa.dshs.wa.gov/providerone/training.htm

If more assistance is needed, contact your JRP who can assist you in locating someone to provide some one-on-one training.

Shared Services

What is a "Shared Service"?

- The term "shared services" refers to a medical service that is available either through Apple Health, RCL or a DSHS waiver.
- Shared services include:
  - Durable Medical Equipment (DME)
  - Occupational Therapy (OT)
  - Physical Therapy (PT)
  - Speech/Communication Therapy
  - Nutrition/Dietitian
  - Psychiatric Med. Management (DDA)

What services are shared?

HCS Shared Services		DDA Shared Services	
Proc/ Svc Code	Proc/Svc Code Description	Proc/ Svc Code	Proc/Svc Code Description
SA875	DME: Bathroom aids, toileting, and supplies	SA875	DME: Bathroom aids, toileting, and supplies
SA876	DME: Communication devices and supplies	SA876	DME: Communication devices and supplies
SA877	DME: Diabetic equipment and supplies	SA877	DME: Diabetic equipment and supplies
SA878	DME: Hospital beds and supplies	SA878	DME: Hospital beds and supplies
SA879	DME: Miscellaneous	SA879	DME: Miscellaneous
SA880	DME: Mobility aids and supplies	SA880	DME: Mobility aids and supplies
SA881	DME: Nutrition equipment and supplies	SA881	DME: Nutrition equipment and supplies
SA882	DME: Orthotic equipment and supplies	SA882	DME: Orthotic equipment and supplies
SA883	DME: Ostomy care	SA883	DME: Ostomy care
SA884	DME: Respiratory equipment and supplies	SA884	DME: Respiratory equipment and supplies
SA885	DME: Urinary/incontinence equipment	SA885	DME: Urinary/incontinence equipment
SA886	DME: Wheelchairs and accessories	SA886	DME: Wheelchairs and accessories
SA887	DME: Wound care	SA887	DME: Wound care
SA888	Physical Therapy (RCL/WA Roads only)	SA888	Physical Therapy
SA889	Occupational Therapy (RCL/WA Roads only)	SA889	Occupational Therapy
SA890	Nutrition Services (RCL/WA Roads only)	90863	Medication Management, Psychiatric
SA892	Speech/Hearing/Communication Evaluation (RCL/WA Roads only)	SA892	Speech/Hearing/Communication Evaluation
92507	Speech/hearing Therapy (RCL/WA Roads only)	92507	Speech/hearing Therapy
		SA893	Hearing Hardware (coming soon!)

Shared Services: Who pays for DME?

- In order for ProviderOne to pay claims for DME, the provider *must* be Medicare enrolled.
- When shared services are claimed, ProviderOne first checks to see if the service could be covered by Medicare and if the client has Medicare coverage.
- If the client has Medicare coverage and the service is covered by Medicare, ProviderOne will not pay unless the provider submits verification of a Medicare denial with their billing.

FAQS

Q: Must the provider be Medicare enrolled to bill for service to dual eligible clients (both Medicare and Medicaid)?

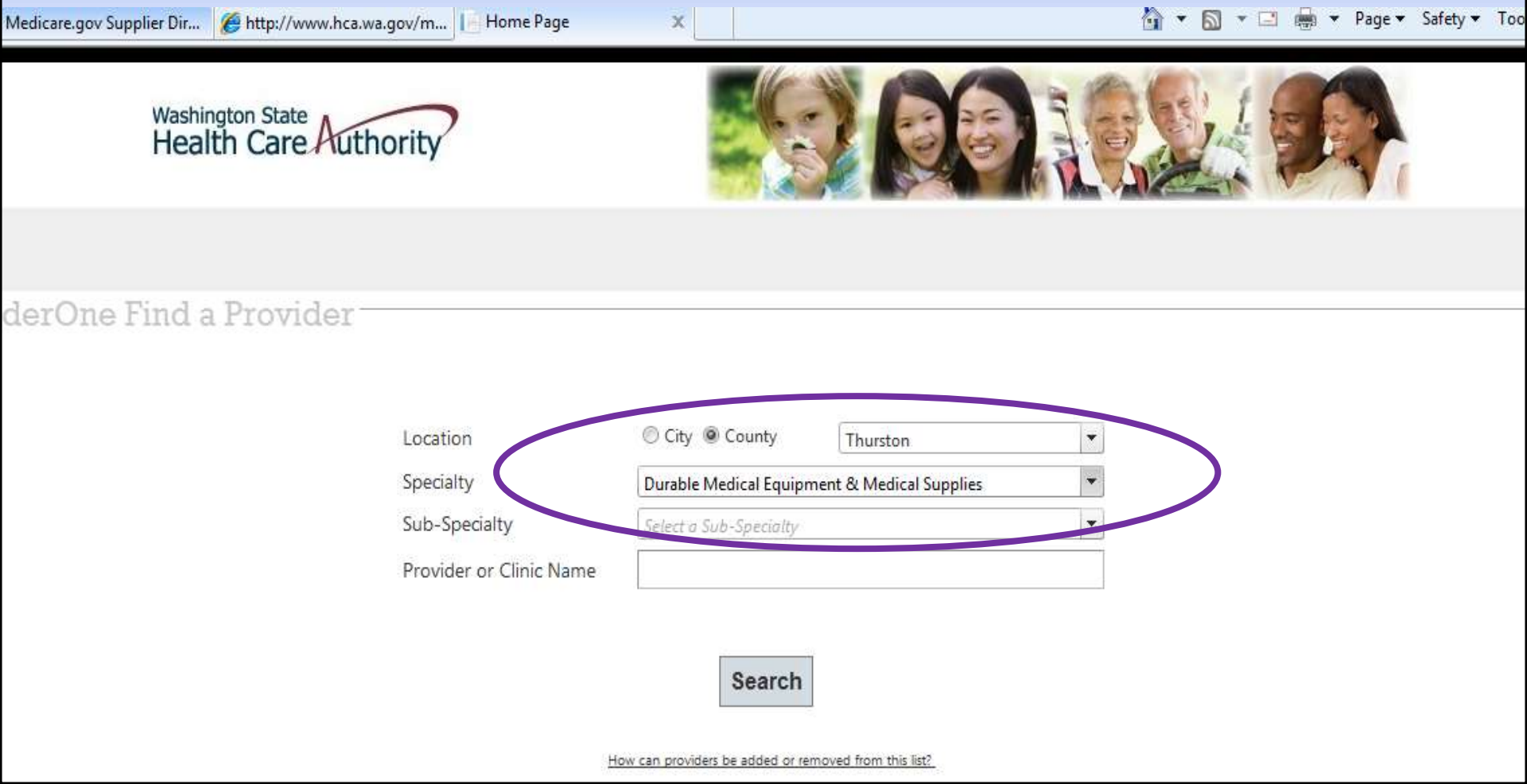
A: For DME vendors, the answer is yes (see previous slide). DME vendors must be Medicare enrolled to have a Core Provider Agreement (CPA) with HCA.

Vendors of other shared services, like a physical or occupational therapy or dietitian/nutritionist, may choose to solely be enrolled in Medicaid, but then they cannot provide services to any clients who are Medicare enrolled, including dually eligible clients.

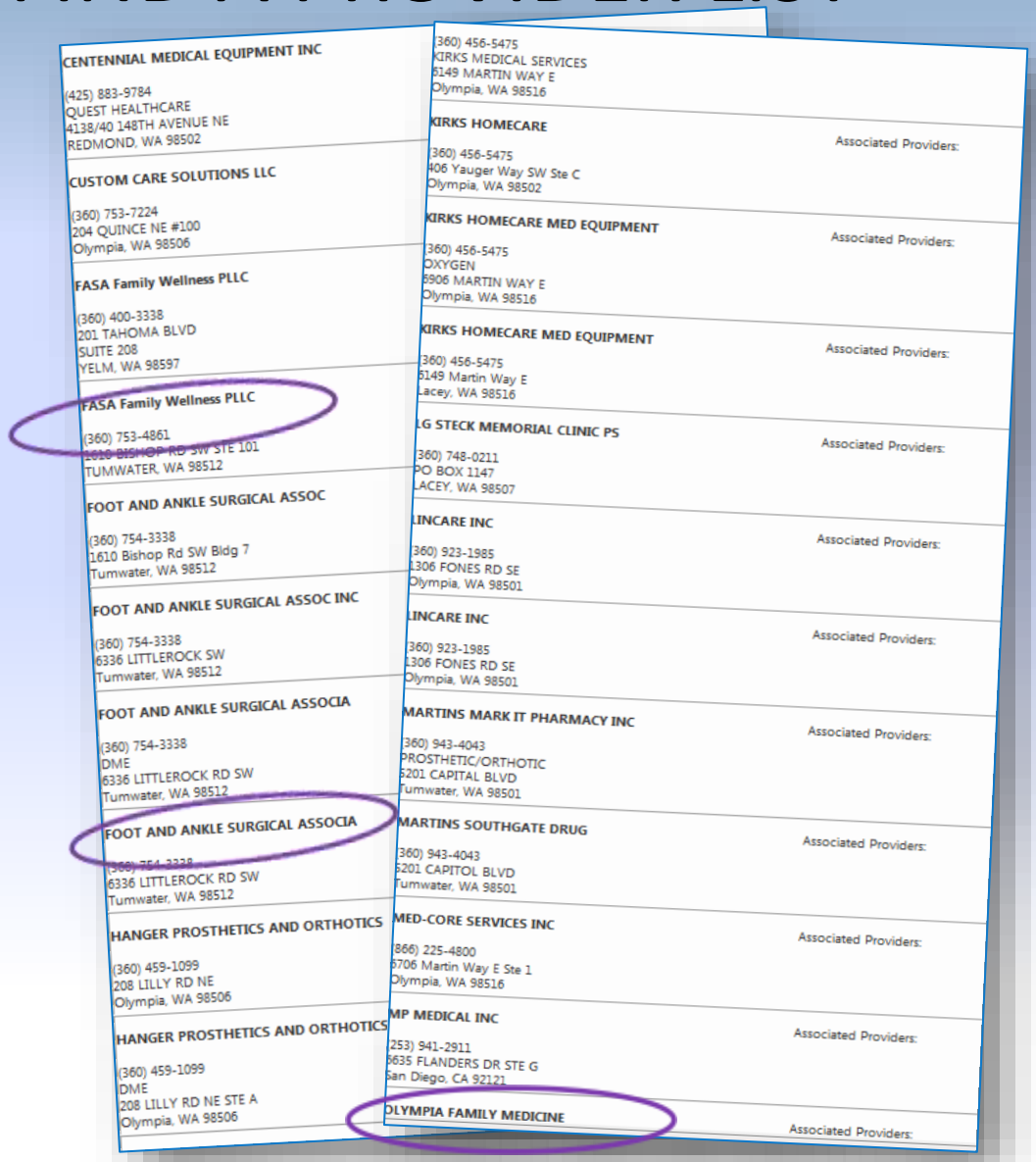
Finding a Provider

Shared Services: Providers

The Find a Provider list has now been updated by HCA to remove providers who are not Medicare enrolled.



FIND A PROVIDER LIST



CENTENNIAL MEDICAL EQUIPMENT INC
(425) 883-9784
QUEST HEALTHCARE
4138/40 148TH AVENUE NE
REDMOND, WA 98502

CUSTOM CARE SOLUTIONS LLC
(360) 753-7224
204 QUINCE NE #100
Olympia, WA 98506

FASA Family Wellness PLLC
(360) 400-3338
201 TAHOMA BLVD
SUITE 208
YELM, WA 98597

FASA Family Wellness PLLC
(360) 753-4861
1610 BISHOP RD SW STE 101
TUMWATER, WA 98512

FOOT AND ANKLE SURGICAL ASSOC
(360) 754-3338
1610 Bishop Rd SW Bldg 7
Tumwater, WA 98512

FOOT AND ANKLE SURGICAL ASSOC INC
(360) 754-3338
6336 LITTLEROCK SW
Tumwater, WA 98512

FOOT AND ANKLE SURGICAL ASSOCIA
(360) 754-3338
DME
6336 LITTLEROCK RD SW
Tumwater, WA 98512

FOOT AND ANKLE SURGICAL ASSOCIA
(360) 754-3338
6336 LITTLEROCK RD SW
Tumwater, WA 98512

HANGER PROSTHETICS AND ORTHOTICS
(360) 459-1099
208 LILLY RD NE
Olympia, WA 98506

HANGER PROSTHETICS AND ORTHOTICS
(360) 459-1099
DME
208 LILLY RD NE STE A
Olympia, WA 98506

(360) 456-5475
KIRKS MEDICAL SERVICES
6149 MARTIN WAY E
Olympia, WA 98516

KIRKS HOMECARE — Associated Providers:
(360) 456-5475
406 Yauger Way SW Ste C
Olympia, WA 98502

KIRKS HOMECARE MED EQUIPMENT — Associated Providers:
(360) 456-5475
OXYGEN
6906 MARTIN WAY E
Olympia, WA 98516

KIRKS HOMECARE MED EQUIPMENT — Associated Providers:
(360) 456-5475
6149 Martin Way E
Lacey, WA 98516

LG STECK MEMORIAL CLINIC PS — Associated Providers:
(360) 748-0211
PO BOX 1147
LACEY, WA 98507

LINCARE INC — Associated Providers:
(360) 923-1985
1306 FONES RD SE
Olympia, WA 98501

LINCARE INC — Associated Providers:
(360) 923-1985
1306 FONES RD SE
Olympia, WA 98501

MARTINS MARK IT PHARMACY INC — Associated Providers:
(360) 943-4043
PROSTHETIC/ORTHOTIC
6201 CAPITAL BLVD
Tumwater, WA 98501

MARTINS SOUTHGATE DRUG — Associated Providers:
(360) 943-4043
6201 CAPITOL BLVD
Tumwater, WA 98501

MED-CORE SERVICES INC — Associated Providers:
(866) 225-4800
6706 Martin Way E Ste 1
Olympia, WA 98516

MP MEDICAL INC — Associated Providers:
(253) 941-2911
5635 FLANDERS DR STE G
San Diego, CA 92121

OLYMPIA FAMILY MEDICINE — Associated Providers:

The Find a Provider List includes providers who may not provide DME for a social services authorization (such as a medical clinic, surgery center or pharmacy). Appearing on the list after filtering for *Durable Medical Equipment and Medical Supplies* just means the provider bills for reimbursement for DME from HCA (but they may not be a DME vendor).

Finding a DME provider

When you are reviewing the list, use your common sense. If you have any question about who is an authorized DME vendor, call and ask the provider. If you have difficulty finding a qualified provider and your JRP or SSPS coordinator cannot help, please contact any of the program managers listed on the last slide of the presentation.

FAQS

Q: Are DME vendors limited to the county on which they appear on the Find a Provider List?

A: No. DME vendors with a CPA can provide services anywhere in the state or provide mail order services, if they choose. Many have chosen a specific geographic area they cover. You can call a vendor to find out what areas of the state they cover or if they do mail order.

Q: Is there a central list of DME vendors that do mail order?

A: Not at this time, but you can email the DME@hca.wa.gov mail box to get information.

Q: Can I order DME online from places like Amazon?

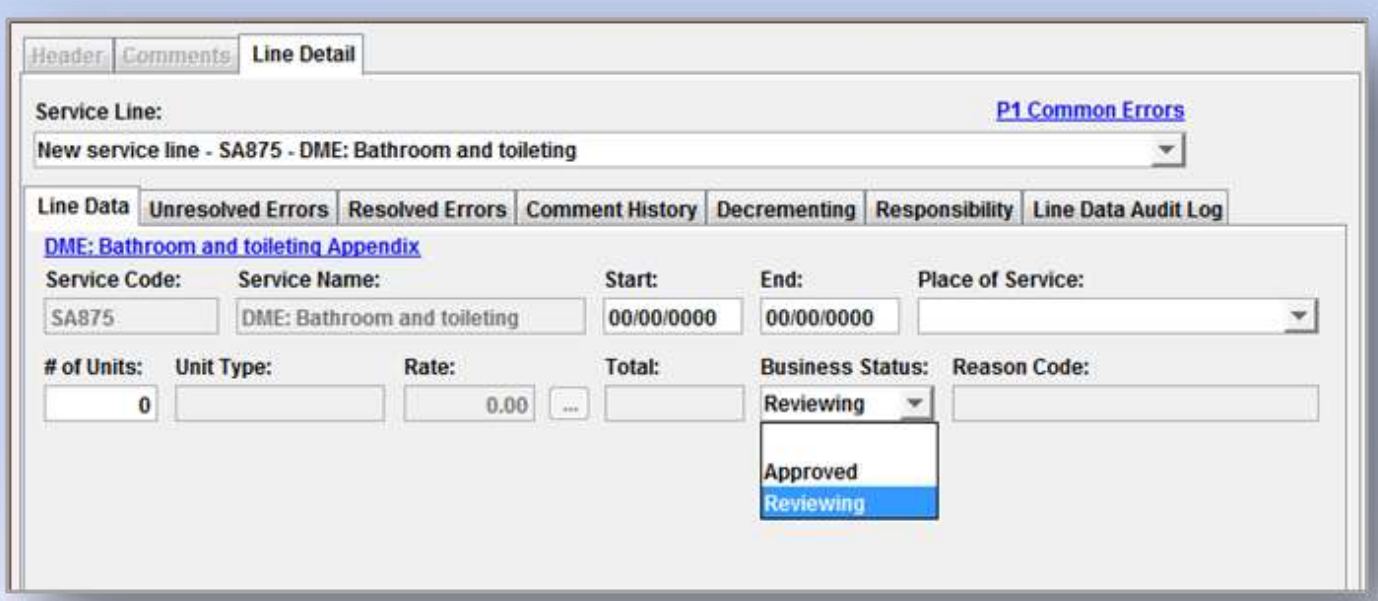
A: It depends:

1. Covered items and typically not covered items require a contract to be in place so those cannot be ordered via Amazon or other online stores. You must use a vendor with a CPA for these items.
2. Never covered items may be ordered from online vendors such as Amazon using a PCard authorized for client purchases.

Authorizations & Service Codes

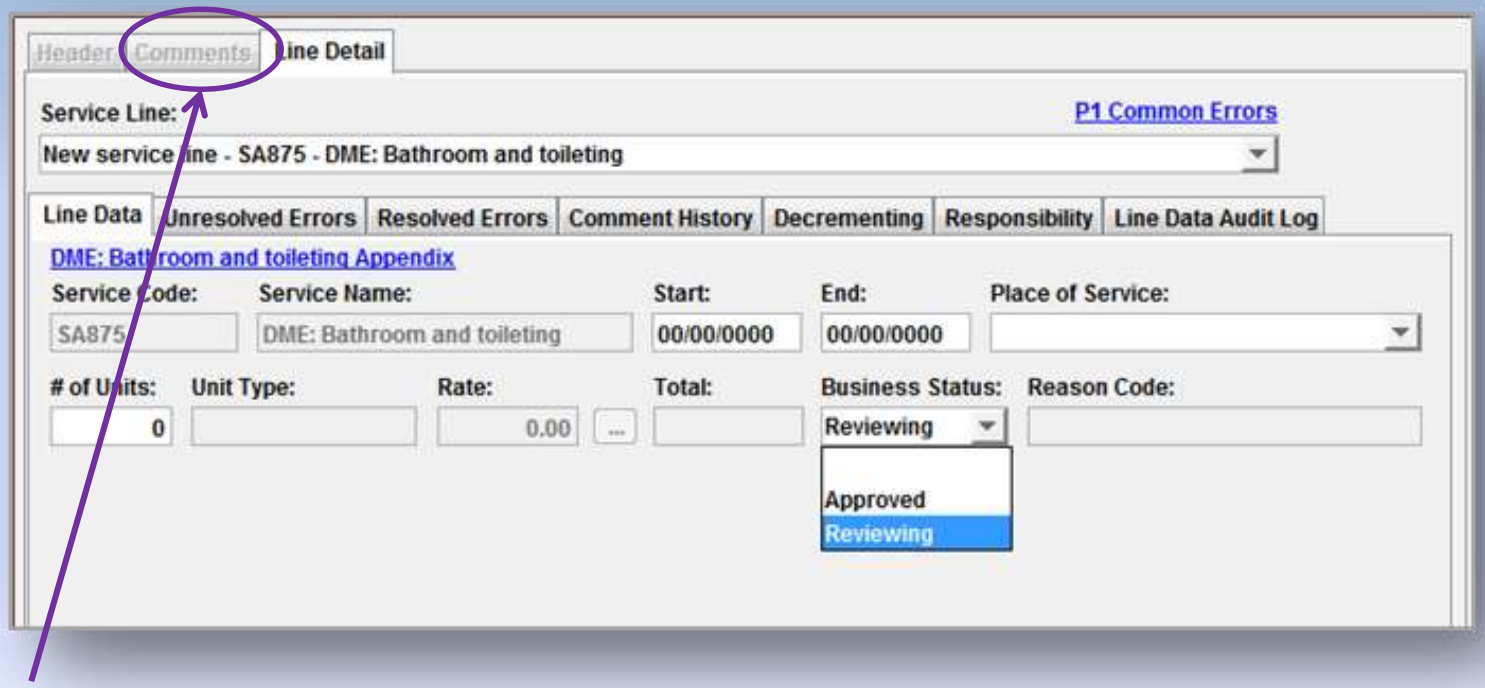
Shared Services: Authorizing DME

Additional functionality has been added to CARE to assist in the authorization of some services, including DME.



Case workers must now select whether the *Business Status* of an authorization is "Reviewing" or "Approved" when authorizing DME. This allows the case worker to enter the authorization for the provider, but prevents payment until it has been verified that the goods or service has been received.

Shared Services: Authorizing DME



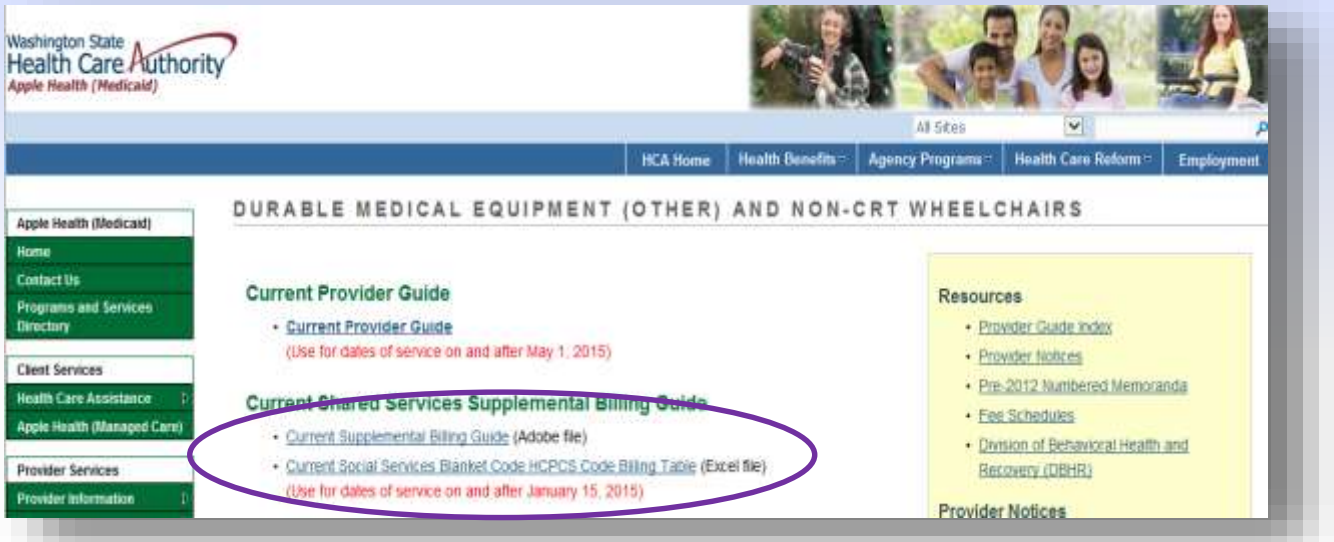
Case workers must also list the specific item(s) being purchased in the Comment box of the authorization.

Authorizations for other services will continue to default to "Approved" when they are created.

FAQS

Q: How do we know which code to use?

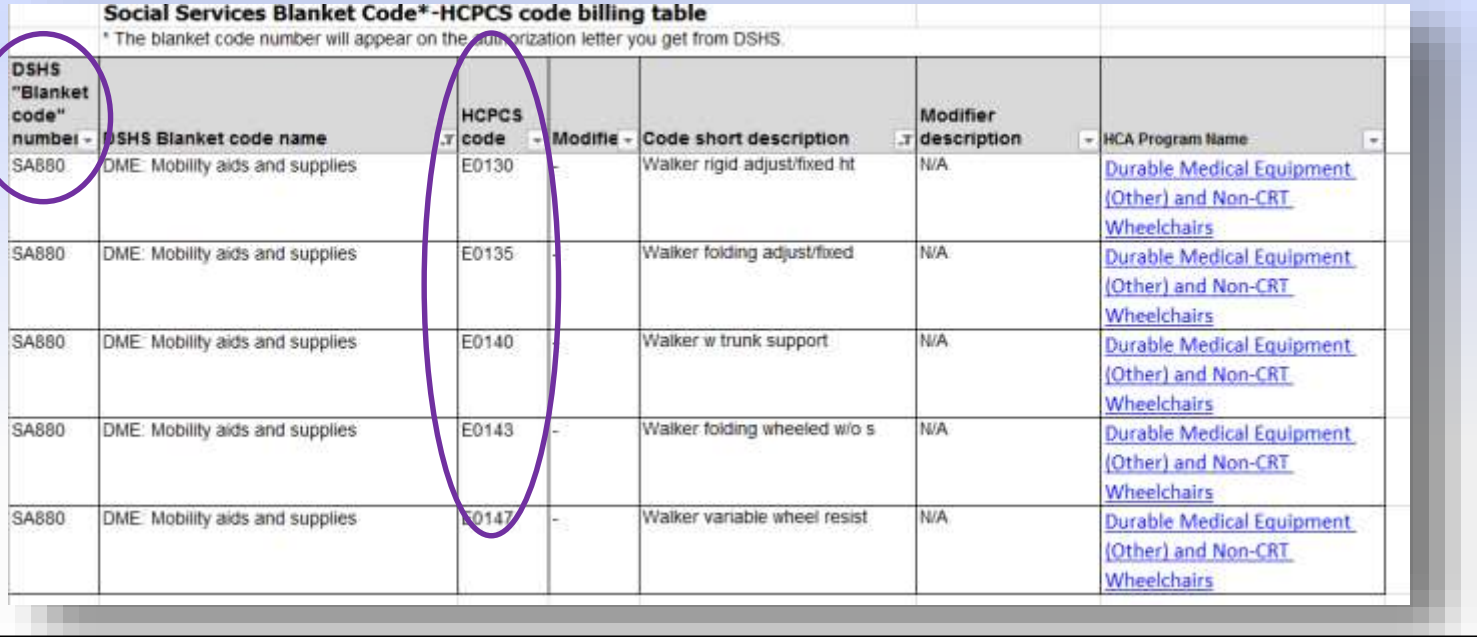
A: For blanket codes, each code has a corresponding list of detailed HCPCS codes (HCPCS is the code the vendor must use when they bill but case workers do not need to know most of these codes). You can see the comprehensive list of detailed codes in a spreadsheet linked to the DME Supplemental Billing Guide (for your information only; staff do NOT need to know the detailed codes).



FAQS

Q: How do we know which code to use (con't)?

A: In most cases, the case worker only needs to know the blanket code. There are some specific codes that may need to be authorized. The vendor must bill using the specific HCPCS code. For example, to authorize a walker, the case worker authorizes SA880. Depending on the type of walker dispensed, the vendor will claim using one of the HCPCS codes under the authorized blanket code.



Social Services Blanket Code*-HCPCS code billing table

* The blanket code number will appear on the authorization letter you get from DSHS.

DSHS "Blanket code" number	DSHS Blanket code name	HCPCS code	Modifie	Code short description	Modifier description	HCA Program Name
SA880	DME: Mobility aids and supplies	E0130	-	Walker rigid adjust/fixed ht	N/A	Durable Medical Equipment (Other) and Non-CRT Wheelchairs
SA880	DME: Mobility aids and supplies	E0135	-	Walker folding adjust/fixed	N/A	Durable Medical Equipment (Other) and Non-CRT Wheelchairs
SA880	DME: Mobility aids and supplies	E0140	-	Walker w trunk support	N/A	Durable Medical Equipment (Other) and Non-CRT Wheelchairs
SA880	DME: Mobility aids and supplies	E0143	-	Walker folding wheeled w/o s	N/A	Durable Medical Equipment (Other) and Non-CRT Wheelchairs
SA880	DME: Mobility aids and supplies	E0147	-	Walker variable wheel resist	N/A	Durable Medical Equipment (Other) and Non-CRT Wheelchairs

FAQS

Q: Most agencies (clinics, hospitals, DME suppliers) have billing specialists because of how detailed and comprehensive billing can be. Are you expecting case workers to be billing specialists?

A: No. Case workers only need to be aware of blanket codes and a few other codes. It is the vendor who must be informed of the detailed codes.

CM uses blanket code

Vendor uses the detailed code to claim

Social Services Blanket Code*-HCPCS code billing table

* The blanket code number will appear on the authorization letter you get from DSHS.

DSHS "Blanket code" number	DSHS Blanket code name	HCPCS code	Modifie	Code short description	Modifier description	HCA Program Name
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SA880	DME: Mobility aids and supplies	E0140	-			urable Medical Equipment ther) and Non-CRT heelchairs
SA880	DME: Mobility aids and supplies	E0143	-	Walke iding wheeled w/o s	N/A	Durable Medical Equipment (Other) and Non-CRT Wheelchairs
SA880	DME: Mobility aids and supplies	E0147	-	Walker variable wheel resist	N/A	Durable Medical Equipment (Other) and Non-CRT Wheelchairs

SHARED SERVICES: REPAIR

- Medicare and/or Apple Health will sometimes cover for the repair of equipment when certain criteria are met with a prior authorization.
- If an individual has equipment that needs to be repaired, the client should contact the DME vendor where the equipment was originally purchased (with the assistance of the case worker or physician's office).
- If returning to the vendor where the original purchase was made is not an option, a repair can be pursued from another DME vendor with a CPA.
- Authorize repair using K0739

FAQS

Q:Is there a list of contracted providers and what equipment is allowed?

A. See HCA's Find a Provider List for a list of vendors. WAC 182.543 provides statute regarding what is covered and non-covered under Medicaid.

Q: Is there anything I can provide to vendors to assure them that they will be paid so they will order and ship the equipment our clients' need?

A: Yes. 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.
- If signing the invoice, the case worker must include the statement "Not to exceed the Medicaid reimbursement rate" with their signature.
  - 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.
  - The provider will be paid at the Medicaid reimbursement rate or the authorized rate, whichever is lower.

FAQS

Q: If a client is denied DME, do we need to send out a Planned Action Notice (PAN)?

A: No.

Q: DME is identified in CARE. Vendor seeks coverage through insurance before a social service authorization created. Do we wait to see if item is denied by other sources before sending approval PAN?

A: Yes you should wait. We should not send an approval PAN if there is still a potential payer.

FAQS

Q: Do we pay for travel time & diagnosis of equipment that needs to be repaired (i.e. wheelchair purchased less than 5 years ago)? What is the process to make payment?

A: No, travel and time spent to diagnosis problems are not compensated [see WAC 182-543-9000(8)].

Competitive Bidding: Medicare

Competitive Bidding: Medicare

- The information regarding competitive bidding for Medicare covered clients is for your information only; no follow up is necessary. You may hear from a client with Medicare coverage that a vendor was unable to fill their order for a wheelchair, for example. This section explains why this may occur.

Competitive Bidding: Medicare

- In 2011, Congress mandated a Competitive Bidding program for selected DME, Prosthetics, Orthotics and Supplies (DMEPOS) in nine locations in the country.
- In 2013, the program expanded to additional parts of the US. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which should reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

COMPETITIVE BIDDING: MEDICARE

- Under the program, a competition among suppliers who operate in a particular competitive bidding area (CBA) is conducted.
- Suppliers are required to submit a bid for selected products.
  - Not all products or items are subject to competitive bidding.
  - Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards.
  - Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount.

COMPETITIVE BIDDING: MEDICARE

Items that must be purchased by the winning bidder through the competitive bidding process for clients with Medicare coverage include :

- Diabetic testing supplies
- Ambulatory aids
- Power wheelchairs
- Standard manual wheelchairs
- Negative Pressure wound therapy (VAC)
- External infusion pumps and supplies
- Oxygen
- Hospital beds
- Additional items may be added in future bid cycles

COMPETITIVE BIDDING: MEDICARE

•Vendors in an area covered by the CBA that were not awarded the bid for an item that is included in competitive bidding must inform clients with Medicare coverage that they are not able to supply the equipment or supplies and that the client must work with a different supplier to obtain the needed item when the item is covered by Medicare.

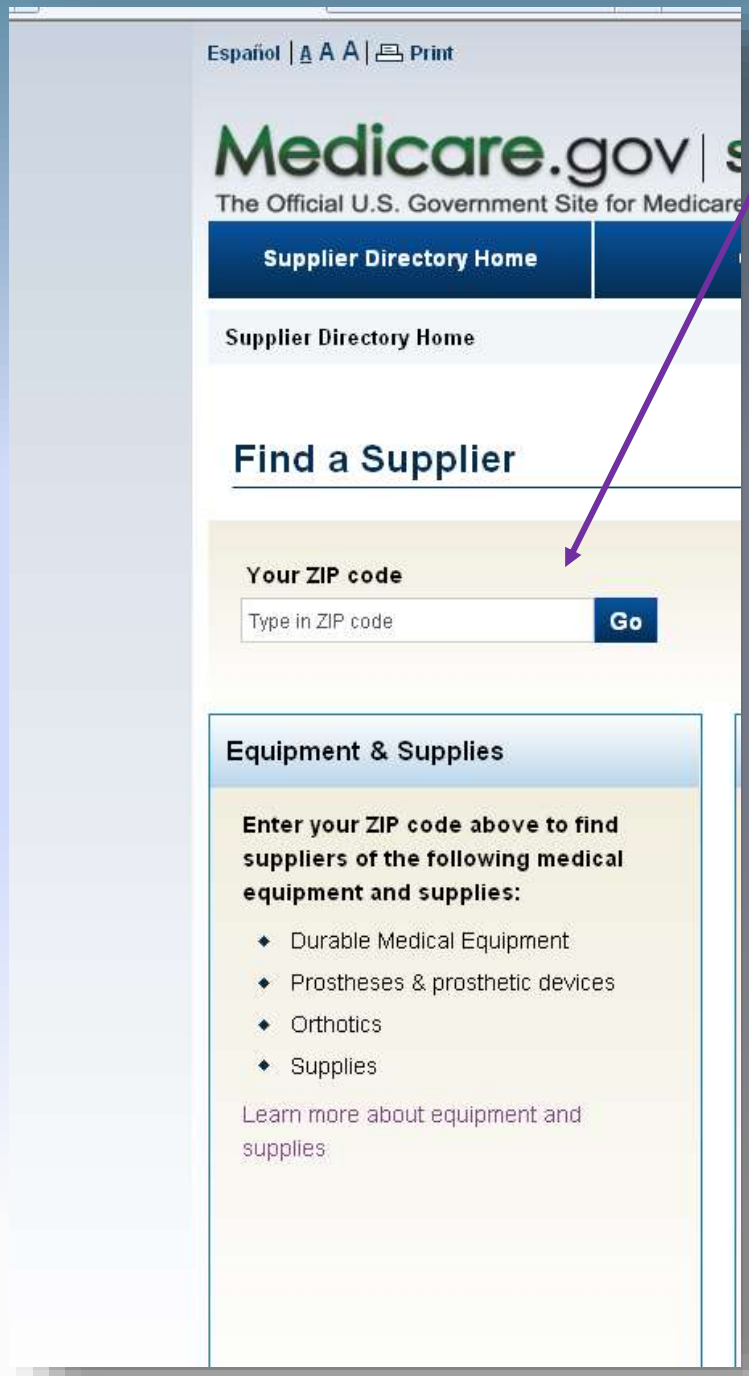
•The case worker may need to assist the client in determining the vendor with the winning bid by looking at the Medicare Supplier Directory.

COMPETITIVE BIDDING: MEDICARE

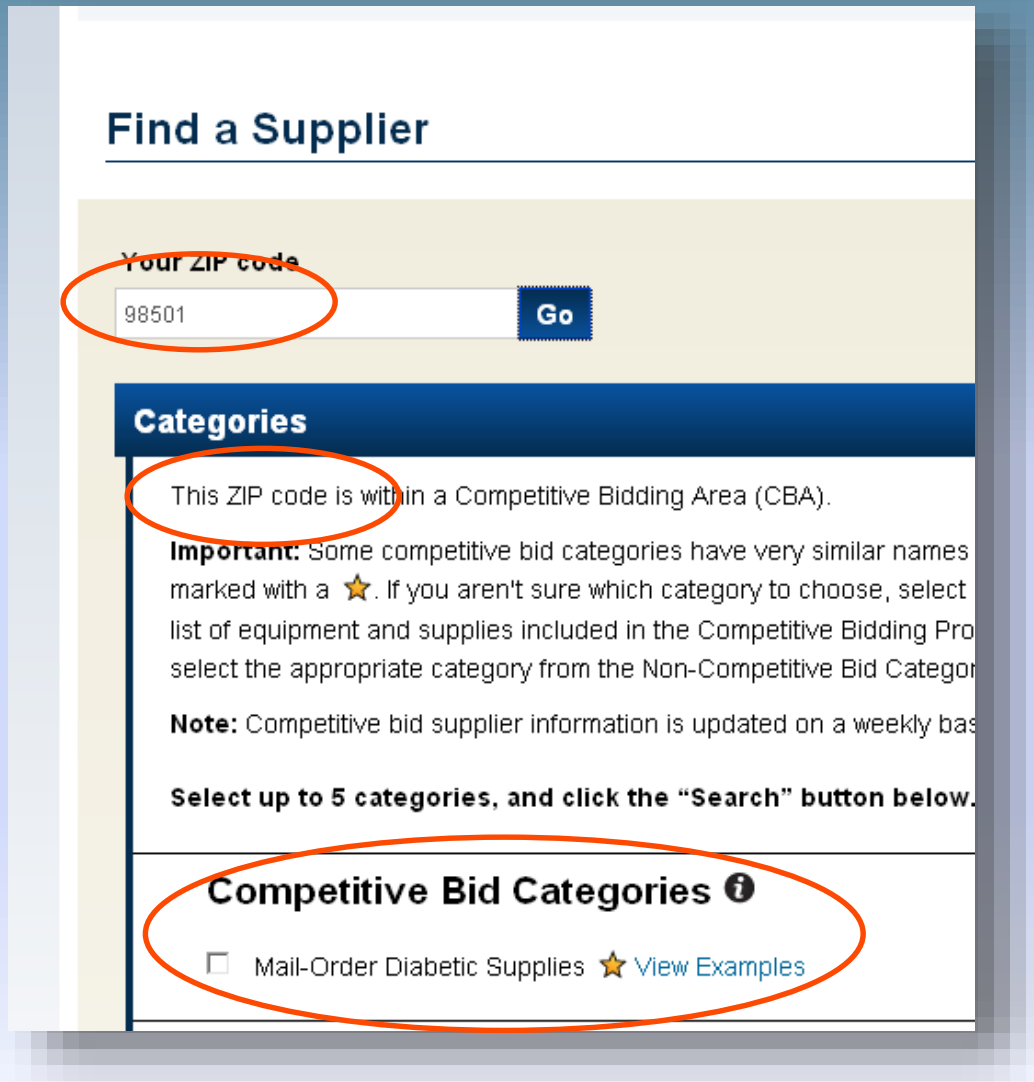
Washington State has Zip Codes which are included in two CBA's:

- Vancouver (Clark and part of Skamania Counties)
- Seattle-Tacoma-Bellevue (includes Snohomish County)
- NOTE: additional Zip Codes may be added in the future.

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



Type in the Zip Code to find out if a county is included in a CBA and for what items. You can then find which vendors were awarded the winning bid for an area. There is additional help on the Medicare.gov website.

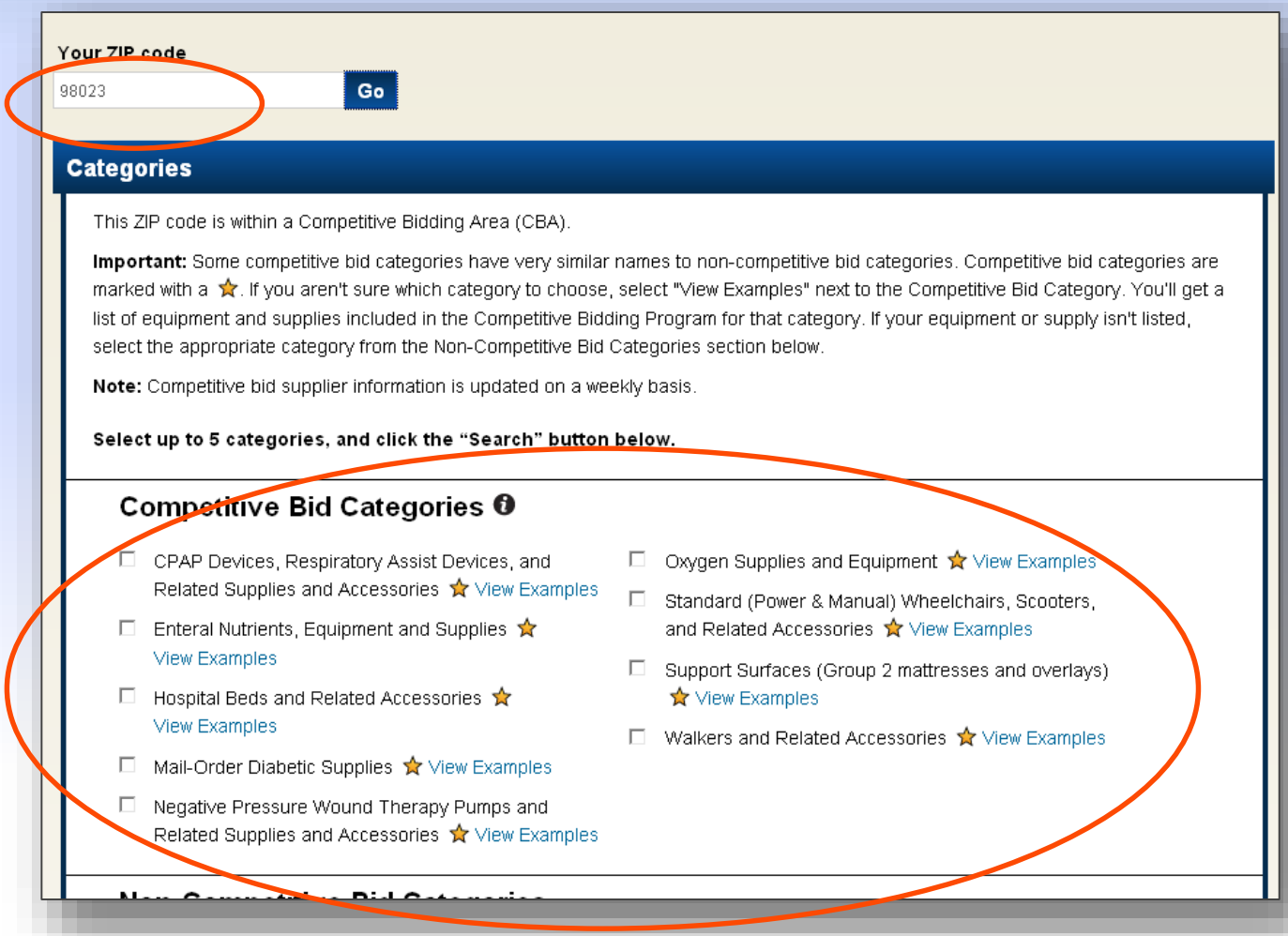


The entire US is in a CBA for mail order diabetic supplies (Medicare clients can get them from a local pharmacy, but if they prefer mail order, they must use the winning bidder).

Searching by Zip Code will display the categories of what items must be purchased by the winning bidder.

Remember: Competitive Bid ONLY applies to:

- **Specific counties for specific Medicare covered items**
- **Medicare enrollees**



FAQS

Q: If the doctor gives a script to a DME provider, does it automatically go to the winning bid vendor?

A: No. If the prescription for a client enrolled in Medicare goes to a vendor that was not the winning bidder, the vendor must refer the individual to the winning bidder.

Q: Is it the case worker's duty to call around to find a winning bid for a manual w/c? How many bids are required?

A: No, the case worker is not involved in this process; it is run by CMS. The bidding is done on a national level on a three year cycle with the winning bidder getting a contract with Medicare for the item.

Remember, a case worker does not create an authorization for items covered by Medicare; this is coordinated through their medical provider.

FAQS

Q:How should I deal with a vendor who refuses to get a denial first (historically, this has occurred frequently)?
A: Refer to HCA's Find a Provider list to find a different provider who will follow billing rules. You can also send an email to the DME@hca.wa.gov mailbox.

Q: I continue to encounter providers unwilling to go through the process of getting denial letters, but are willing to provide specific Medicare policy/regulations citing why certain equipment/repairs are not covered. Can this be accepted in lieu of a denial letter?
A: YES if client is a dually eligible client (Medicare/Medicaid) the DME provider can add Medicare information to Box 30.

Q: If I need to find a new vendor, can I ask for the prescription back?
A: The client can request to have it returned or transferred. The

My Client Needs DME: The Process

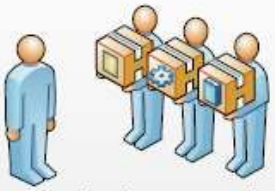
Action: Authorizations

- Do not create any social service authorizations until all other available funding sources have been accessed.
- Remember: social services authorizations are not to be used to supplement Medicare or Apple Health rates.

Client needs DME

1. The client gets a Rx from their MD (with the family or CM assisting, as necessary).
2. The client provides the Rx to the DME vendor.

If covered or typically not covered and the client has private insurance, Medicare or Medicaid



Vendor dispenses the item

If the client has Medicare/private insurance and the item is a covered benefit, DME vendor bills insurance or Medicare

If approved

The vendor is paid for the goods the client received.
No follow up necessary from the case worker.

If not covered by Medicare or denied

If approved

The vendor pursues billing Medicaid.
If the item is covered, it may require a Prior Authorization.
If it is typically not covered, it will require an ETR

Vendor claims in P1

If denied

The vendor contacts the case worker to inform them of the denial.

After verifying the client received the item, the case worker changes the authorization's status to "Approved".

If item is never covered by Medicare **and** Medicaid or the client is not covered by Medicare/Medicaid

NOTE: The DME provider can submit an invoice to the case worker along with documentation of a prescription from the client's medical provider. A signature from the case worker is acknowledgement that a social services authorization will be created if all other payor sources deny. The item will be reimubursed at the Medicaid rate (which should be noted by the case worker).

If the item is necessary for independent living, the case worker creates social service authorization in Reviewing status.

Vendor provides the item to the client

FAQS

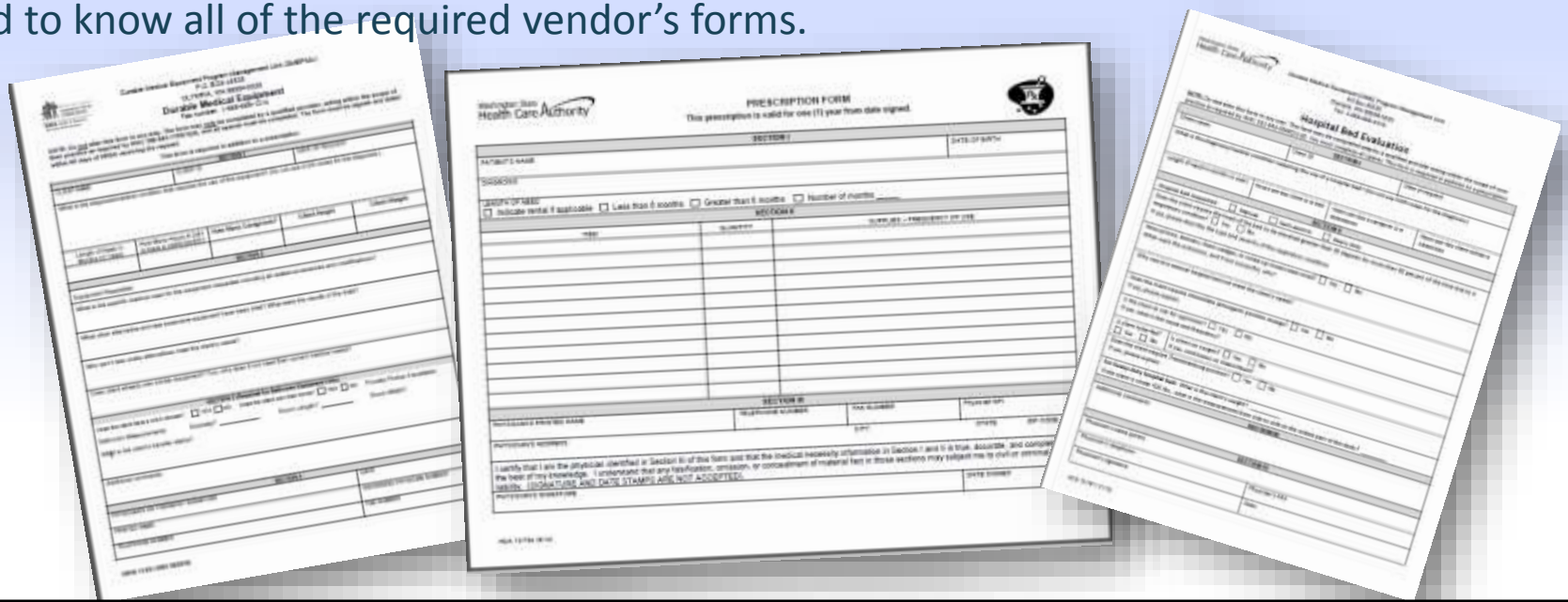
Q:In the flow chart, it is indicated that the clients gets the prescription from their doctor and provides it to the DME vendor. Can't the vendor just get the prescription for the client?

A. Vendors are frequently hesitant to go directly to a physician to get a prescription because that can be viewed as "soliciting", which they cannot do. A case worker or family member can assist the client, as necessary, to get the needed prescription. Some DME vendors will also assist with this process.

FAQS

Q: We have heard from vendors that the DME prescription cannot be written on a regular prescription pad; that these must be on a HRSA form. Can we get a copy of this blank form to assist the vendor?

A. **It is the responsibility of the vendor** to use the appropriate form. If the script was written on a pad and a form is needed, the vendor can contact the physicians office to get it on the form. For case workers information (only), forms can be found at http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx. Remember: this is the vendor's regular business practice; they have been using these forms for a long time. Case workers do not need to know all of the required vendor's forms.



FAQS

Q: At what point in the social service authorization process is a vendor expected to deliver the equipment?

A: Currently, we expect equipment to be delivered following social service authorization. The provider bills after delivery. Many items require a date of delivery and serial number to be entered prior to being able to bill. This is how all of our Medicaid services are provided (service first, payment after).

Q: How is shipping to be authorized for DME if there is a shipping and handling fee?

A: Shipping is included in the DME rate. There should be no additional charge for shipping per WAC 182-543-9000(8)(b)(d).

Private Insurance/ Medicare/Medicaid

Prior Authorizations

- Prior Authorization (PA)
- Expedited Prior Authorization (EPA)
- Exception to Rule (ETR)
- Limitation Extension (LA)

Prior Authorizations

For clients who have a medical benefit such as private insurance, Medicare or Apple Health:

- The client must first coordinate with their health care provider to acquire the needed item or service through Medicare, private insurance, Apple Health or other available benefit.

PRIOR AUTHORIZATIONS

- It is the DME vendor's responsibility to be aware of the process and forms needed to request a prior authorization, exception to rule (ETR) or limit extension, as needed, under the client's medical benefit plan.
- Per their Core Provider Agreement (CPA), DME vendors must exhaust other coverage before submitting a request for payment under a social services authorization.

PRIOR AUTHORIZATIONS

- For covered, a prior authorization or limit extension must be requested by the DME vendor and denied by HCA before a social service authorization is pursued.
- For typically not covered items, an exception to rule must be requested by the DME vendor and denied by HCA before a social service authorization is pursued.
- Items that are “never covered” do not require a denial from HCA before creating a social service authorization.

Medically necessary (WAC 182-500-0070)

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.

EXCEPTION TO RULE (ETR)

- HCA's WAC which lists Medicaid non-covered items includes items that may be covered under specific circumstances through an HCA exception to rule (ETR) process (the DME vendor should be knowledgeable about this option). These are what we are referring to as the "typically not covered" items.
- It can be important for the case worker to provide specific information to the vendor regarding the client's need for the item. This should be included in the vendor's request for an ETR (for example, provide clinical information why the item is necessary).

PRIOR AUTHORIZATION OR ETR DENIALS

If the item was denied, the following steps should be followed:

1. The case worker should evaluate the need for the item to determine if the item is truly necessary.
2. When a covered item is denied by a client's medical benefit, both the vendor and the client receive a denial letter. If it is determined the item is truly necessary, the case worker must obtain a copy of the denial letter issued by the other funding source (e.g. Medicare or Apple Health). This is a temporary way to verify that all other payer sources have been exhausted first.

Coming soon: instructions on viewing denial information in ProviderOne.

PRIOR AUTHORIZATION OR ETR DENIALS

If the item was denied, (con't):

3. DME coverage under all medical benefits is based on medical necessity. If an item was denied because medical necessity was not demonstrated but is considered necessary for independent living, the case worker should document in a SER why the item is needed by the client.
4. Create an authorization in CARE putting the authorization in "Reviewing" status until it has been verified the client has received the equipment/item(s).
5. Once verification that the client has received the item, the case worker must change the authorization status to "Approved" in a timely manner.

NOTE: CLAIM PAYMENT DENIAL

Remember:

- A DME vendor could be denied payment from a medical benefit provider because the vendor's medical claim was missing necessary information such as the prescribing medical personnel's National Provider Identifier (NPI) or the ICD-code, etc. The vendor must make the necessary corrections in order to receive payment through ProviderOne. This does not constitute denial of *benefit* to the client.
- Just because a denial occurred does not mean a social service authorization should be created.

NOTE: PRIOR AUTHORIZATION REJECTION

Also:

•A DME vendor's prior authorization request could be rejected because the request was missing necessary information such as the prescribing medical personnel's National Provider Identifier (NPI) or the ICD-code, or the information is illegible, etc. The vendor must make the necessary corrections and resubmit the request in order to receive approval. A rejection does not constitute denial of *benefit* to the client.

•Just because a rejection occurred does not mean a social service authorization should be created.

FAQS

Q: When a provider gets a denial for missing information are they told that in the denial letter or is it just a form denial letter with a blanket denial reason?

A: The vendor is informed of the reason for the denial or rejection.

Q: What does a vendor do to resolve a rejection due to missing or illegible information?

A: DME Providers do the following to resolve Rejection errors:

- Send the reference number to the DME Mail box with REJECTION in the Subject line
- Call the DME toll-free line 1-800-562-3022

FAQS

Q: What is the difference between prior authorization and Exception to Rule (ETR) in Medicaid?

A: We will cover this in several slides:

Authorization: All DME providers are required to obtain authorization for **covered** DME and related supplies and equipment.

There are three types of prior authorization:

- Prior Authorization (PA)
- Expedited Prior Authorization (EPA)
- Limitation Extension (LE)

FAQS

Prior Authorization:

Under WAC 182-543-7100, **HCA** requires providers to obtain PA for certain **covered** items and services before delivering that item or service to the client, except for dual-eligible Medicare/Medicaid clients when Medicare is the primary payer. The item or service must also be delivered to the client before the provider bills the agency. HCA requires specific information as part of the PA process.

The agency considers requests for new durable medical equipment (DME) and related supplies that do not have assigned health care common procedure coding system (HCPCS) codes, and are not listed in the provider guide. These items require PA.

Expedited Prior Authorization (EPA):

The expedited prior authorization (EPA) process is designed to eliminate the need for written or telephone requests for prior authorization for **selected, covered DME procedure codes**. (WAC 182-543-7300)

FAQS

Limitation Extension (LE):

Medicaid limits the amount, frequency, or duration of certain covered DME, and related supplies, and reimburses up to the stated limit without requiring prior authorization (PA).

Certain covered items have limitations on quantity and frequency. These limits are designed to avoid the need for PA for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client.

The agency requires a provider to request PA for a LE in order to exceed the stated limits for nondurable medical equipment (DME), and medical supplies. (**WAC 182-543-7200**)

FAQS

Exception to Rule:

HCA evaluates a request for any DME, related supplies, and related services listed as **non-covered** under the provisions of WAC 182-501-0160 (the items listed as typically not covered only; no ETR is submitted for never covered items).

Bottom line:

- **PA** is the process to obtain or extend limits on specific **covered items**
- **ETR** is the process to obtain items that are **typically not covered.**

FAQS

Q: Does Medicaid allow for an expedited DME process for imminent nursing facility discharge or for an in-home client who needs an item for their safety?

A: Yes; the vendor must:

1. Request a prior authorization with "Expedite for d/c" or "Home client: safety issues" in the comments section of the request form; and
2. Email DME@hca.wa.gov and include in the subject line "Expedite for d/c" or "Home client: safety issues"
3. 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.
4. The vendor should include in the email the client's P1 ID and the authorization number.

FAQS

Q: Does P1 allow for a case worker to authorize the rental of DME? If so, what is the process?

A: The process for renting is the same as for purchasing. The vendor will use a different modifier. For nursing facility discharges, use the expedited process.

FAQS

Q. What if an upgrade is medically necessary?

A: The vendor must explain why the upgrade is necessary in the PA process.

Q. What if an upgrade is not medically necessary but the client prefers the upgrade and will pay privately for it? Can financial use the amount paid by the client as a participation adjustment?

A. No, because the upgrade was not medically necessary.

FAQS

Q: I have heard that Medicare will only pay for a 4 wheeled walker but not for the brakes or seat that my client needs on the walker. How is it paid for? Is this considered "up selling" to supplement the Medicare reimbursement rate?

A: If Medicare denies additional elements to the standard walker the vendor can submit a prior authorization or ETR to HCA along with the Medicare denial. If Medicaid denies the prior authorization or ETR, follow the process that provided in today's presentation. Purchasing additional parts to standard equipment, when necessary, in not considered supplementing the rate.

FAQS

Q: How long does it take HCA to process an ETR?

A: HCA tries to look at ETR requests as they are submitted. The goal is within one business day of receipt of the ETR.

Q: Can DME vendors bill for the time it takes them to submit an ETR?
A: No.

Q: Do typically not covered items such as bath equipment still require the client to obtain a prescription from the MD?
A: Yes. The MD may also have to fill out portions of the ETR.

Q: Do never covered items require a prescription?
A: No. But if the provider will bill via ProviderOne, a prescription will be needed.

FAQS

Q: Do never covered items require a prescription?

A: No. Never covered items are not considered medical items so you would use a non-medical equipment or supplies code (SA420 or SA421) to authorize to a vendor with the Specialized Equipment and Supplies contract. Claiming for social services does not require any additional detail codes, diagnosis codes, prescriptions, doctor info, Prior Authorization/Exception To Rule/Limit Extensions, etc. The vendor claims through the social services portal in ProviderOne, not the medical portal.

FAQS

Q: When a vendor receives a denial, how do they know if an ETR is required or if a social services authorization is the next step?

A. Remember, the ETR process is followed only for 'typically not covered' items. The PA process is followed for covered items. An ETR would not be requested for an item that was denied through the PA process. Regardless of whether the denial is for an ETR or PA, the same process described earlier in this presentation would be followed if a denial is received. The case worker:

1. Evaluates the need for the item.
2. Verifies that all other payer sources have been exhausted.
3. Documents in a SER why the item is needed by the client.
4. Creates an authorization in CARE putting the authorization in "Reviewing" status until it has been verified the client has received the equipment/item(s).
5. Adds what item is being authorized in the Comments section of the authorization.

FAQS

Q: How do I authorize a portable ramp or other "home modification" equipment like stair lifts?

A: These items are not durable medical equipment and are never covered through Apple Health Medicaid.

- If there will be any construction or modification to a dwelling, authorize using an environmental modification service code to a contracted environmental modification provider.
- If no construction or modification is needed, such as for a portable ramp, use a non-medical service code and a provider with the Specialized Equipment and Supplies contract with the correct taxonomy.

FAQS

Q: We often combine the purchase of grab bars with an environmental modification and the licensed contractor includes the items in an e-mod bid and makes the purchase. Can we continue to do so?
A: Yes.

Q: If equipment is not fully covered by Medicare, will Medicaid cover the co-pay generated by Medicare or other insurance?

A: No.

Q: How about for lost or stolen DME under the 5 year time line for Medicare coverage? How do clients get equipment in this situation?

A: This information should be included in the prior authorization request to Medicaid.

FAQS

Q: For items that are not covered by a medical benefit and social services must purchase a necessary item on a monthly basis is there a way to authorize an ongoing P1 authorization that spans several months (review cycle)?

A: DME Blanket Codes are of the billing type "Span Multiple" and can be authorized for up to 366 continuous days. This means that providers can continue to provide services throughout the period described by the Start Date and End Date and submit claims multiple times until the total amount allowed entered by the case worker on the service line has been fully consumed.

Q: Is there a process to assist with moving DME, such as a hospital bed? Our contracted movers will not be knowledgeable about disassembling and reassembling DME.

A: In the past, providers did this as a courtesy, especially if they were Medicare Primary. Some may still do this. Another option is to use a contracted mover to move the equipment but the DME vendor to disassemble and reassemble the equipment (use SA626 to authorized the disassembly/assembly of the equipment).

UPDATE: Items typically not covered by Medicare/Medicaid

There are some DME items that are not covered by Medicare and not typically covered by Apple Health which may be covered by DSHS (such as bath equipment).

1. The vendor must submit an ETR to Apple Health Medicaid.
2. If denied and the case worker determines the item is necessary for independent living, create an authorization in CARE and put the authorization in “Reviewing” status until it has been verified the client has received the equipment/item(s).
3. Document the item being purchased in the Comments section.

Note: Denials

A denial is not necessary if there is an item that is necessary for the client and:

1. The client's medical benefit has been exhausted; or
2. The item is not covered by the client's medical benefit.

This means for an item that is never covered by Medicaid, a denial is not necessary prior to creating the social service authorization.

Items **never** covered by Medicare/Medicaid

There are some DME items that are not covered by Medicare and are never covered by Apple Health which may be covered by DSHS (such as grab bars, reachers, handheld showers).

1. If the case worker determines the item is necessary for independent living, create an authorization in CARE and put the authorization in “Reviewing” status until it has been verified the client has received the equipment/item(s). No denial is necessary for items never covered by Medicaid.
2. Document the item being purchased in the Comments section.

Clients never covered by Medicare/ Medicaid

If the client has neither Medicare or Medicaid and the item is needed for independent living:

1. If the case worker determines the item is necessary for independent living, create an authorization in CARE and put the authorization in "Reviewing" status until it has been verified the client has received the equipment/item(s). No denial is necessary if the client is not covered by Medicare/ Medicaid.
2. Document the item being purchased in the Comments section.

FAQS

Q: You mentioned there are between 5-10% of our clients who do not have Medicare or Medicaid. Who are they?

A: Clients enrolled in CHORE and the non-citizen programs or for DDA, clients the Individual and Family Services (IFS) state program.

Q: What if my client is running short of incontinence or diabetic supplies each month. Can a limitation extension be requested?

A. Yes. A limitation extension can be requested for a 12 month period.

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)	

FAQ

Q: Is it true that a Medicaid denial is required for every authorization?

A: No, that is not true:

- A Medicaid denial is only necessary if the item is covered or "typically not covered" and the client is on Medicaid.
- A denial is not required if the client is not on Medicaid.
- A denial is not required if the item is never covered.

FAQ

Q: You refer to us to decide if the DME is necessary for independent living, does this mean that we cannot purchase these items for a client in an AFH?

A: No. When we refer to independent living, we are simply referring to a setting that is not an institutional setting such as a hospital, nursing facility, Residential Habilitation Center (RHC), etc.

FAQS

Q: My client has CFC + COPES and is dual enrolled with Medicare/Medicaid. The client needs a bedside commode and a tub transfer bench. What I am understanding is that because Medicare does not cover the items, the provider would send a prior authorization request to Medicaid for that equipment. If the prior authorization is denied by Medicaid, then the DME vendor can send a copy of the denial along with an invoice requesting social service reimbursement for the equipment. Is this correct?

A: The vendor should notify the case worker when denials have been obtained. If the item is necessary for independent living, the case worker follows the previous instructions to create a social service authorization.

FAQS

Q: What about managed plans such Kaiser Hospice who will not cover briefs or other incontinence supplies? How do we supply these items for our clients?

A: For Medicaid clients on hospice, requests for adult diapers go to Nancy Hite, Occupational Nurse Consultant at HCA, for review. She reviews and approves or denies coverage based on the following:

1. If the client had been getting adult diapers prior to the hospice election for incontinence, most of the time these are approved (depending on the circumstances).
2. If the client has a medical condition that is related to the incontinence and the Hospice diagnosis, such as bladder cancer, or new onset altered mental status & bedbound, Hospice is responsible.
3. If the client is residing in a nursing home, hospice is not responsible; the nursing home is responsible. More than likely the client had been getting adult diapers before Hospice was elected.
4. If the client is in an adult family home and had been getting adult diapers prior to Hospice, it depends on the Hospice diagnosis if HCA would cover or Hospice.

FAQS

Q: Case workers feel that the research involved in ordering DME is too time consuming for a shower chair and other bathroom equipment. Can you simply the process?

A: The vendor is responsible for performing the tasks required. Medicaid is working with DSHS to identify a process for these requests to be a priority. Because most DME will be provided through a medical benefit, case workers will be creating fewer authorizations.

NF DISCHARGES & DME

For a client discharging from a nursing facility or other institutional setting:

1. Equipment needs should be evaluated early in the discharge planning process to allow sufficient time to get necessary equipment in place prior to discharge.
2. Case workers should coordinate with nursing facility discharge planners to get all medically necessary equipment through the client's medical benefit whenever possible.
3. Cases should be held by the NFCM until necessary DME has been received by the client. Notice of Denial of payment by Medicare and/or Medicaid may occur after case transfer. If Medicaid denies, the case worker holding the case should create the social service authorization for the denied item.

Did you know?

Medicaid will purchase the following while the individual is in the nursing facility for the residents use in the facility when medically necessary. The equipment belongs to the client and can be purchased even if the client has Medicare coverage. The client takes it with them when they discharge (per WAC 182.543.5700):

- One manual or power-drive wheelchair
- Speech generating devices
- Specialty beds (for example, a low airloss mattress. A heavy-duty bariatric bed is not a specialty bed)

FAQS

Q: Can I use Residential Care Discharge Allowance (RCDA), Community Transition Services (CTS), WA Roads or Residential Allowance Request (RAR) funds to purchase non-covered items such as toilet seat risers and grab bars?

A: Yes, after exhausting other benefits first:

- HCS: CTS funds can be used in conjunction with other benefits and resources available. DME blanket codes were added to the Discharge Resource and WA Roads RACs.
- DDA: for RAR, the supported living provider can purchase the items and be reimbursed.

Q: Must the process laid out for authorizing DME in this presentation be followed for RCL?

A: Yes, this process is determined by federal rule and must be followed for RCL.

Q. How do we pay for DME for Fast Track clients who are not yet approved for Medicaid?

A: Clients who are on COPES Fast Track have access to all of the COPES services. Since ProviderOne will not show that they are enrolled in Medicaid, the system will not look for a denial.

FAQS

Q: If client needs/wants covered items, do we add these to the Care Plan regardless of which payor source pays?
A: If the case manager is aware of this need or want, even though we are not authorizing, it should be included in the Care Plan.

Q: Have any of the DME suppliers that typically provide social service items to our clients been using this ETR process for items that typically aren't covered? We have never heard this process exists and it seems that a 1 day turnaround may be overly optimistic if no one has been using the process.
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.

FAQS

Q: If a case manager tries to create a DME Auth in P1, but client has other coverage, will there be a fatal error message to prevent that SS Auth from being entered?

A: No.

Q: Is DSHS really saving money by purchasing DME using this methodology? I think it may be worthwhile to try to determine how much money the dept. is saving by utilizing other payment sources for DME vs. case workers simply avoiding DME due to the new policies & processes involved.

A: The anticipation is that case workers *will not* be making as many authorizations as in the past. Most DME should come from the client's medical benefit. If WA State did not follow federal statute, we would potentially be at risk for very large fines from the Centers for Medicare and Medicaid (CMS).

FAQS

Q: What about lift chairs?

A: There are two parts to a lift chair: the lift mechanism and the furniture portion. For the lift mechanism:

- Clients with Medicare coverage can have it paid for through Medicare.
- Non-Medicare covered clients can have it paid by using service code SA879.

For the furniture portion:

- Both Medicare and non-Medicare clients can have the furniture portion of the chair paid for through social services using service code SA419.

A Service Code Data Sheet (SCDS) is forthcoming.

FAQS

Q:What happens if I create a social service authorization but the rate I use is higher than the Medicaid reimbursement rate?

A.The provider will be paid at the Medicaid reimbursement rate or the authorized rate, whichever is ***lower***. The social service authorization should be created using the estimated total cost. If the vendor's cost exceeds the reimbursement rate, the vendor has a process for submitting requests to HCA to have the rate increased.

Q: How about if the reimbursement rate is too low and the vendor won't supply the equipment because the actual cost of the item is more than the reimbursement rate?

A. The vendor can request a rate increase using the email address provided earlier: DME@hca.wa.gov

FAQS

Q. So, if the client has RXs for a reacher and a toilet riser, no denial is needed for the reacher and I can go ahead and authorize. But for the toilet riser, I will need a denial from the vendor before I can authorize, correct?

A: Correct. A reacher is never covered but a toilet riser is a typically not covered item so an ETR must be pursued by the vendor.

Q: For DDA, when all other resources have been exhausted (Medicare/Medicaid), is the case worker still required to follow the DDA prior approval process prior to creating a social service authorization? (NOTE: the DDA Prior Approval and the HCA Prior Authorization are two distinct processes.)

A: Yes; all DDA policy is still followed.

FAQS

Q: Can hearing aids or eye glasses be covered through a social service authorization?

A: For DDA: hearing aids only. Use new blanket code SA893. For those under 21, it is part of the client's Apple Health benefit. Eyeglasses are not covered.

For HCS: COPES and RCL do not cover hearing aids or glasses. In New Freedom, a client can use their budget to purchase these items. Hearing aids and eyeglasses cannot be purchased using the $500 spending limit for a client enrolled in CFC.

FAQS

Q: If a DME item has been denied many, many times in the past, does the vendor still need to get a denial for the next client on the same item?

A. Yes. This is because the prior authorization and ETR are specific to an individual's diagnosis and other criteria. If the same client has received a denial for the same item in the same benefit year, no denial is necessary.

Q: What about blood pressure monitors? Are they covered, not typically covered or never covered items?

A: Blood pressure monitors are "typically not covered". An ETR should be requested when a blood pressure monitor is medically necessary for a client.

FAQS

The vendor has asked to be paid to submit a bid as it requires a home visit. Is this acceptable?

A: No; the vendor is prohibited from doing this.

Q: When authorizing DME for multiple items do we do a separate line for each item to be paid for? Or do we do a lump sum payment?

A: You can authorize using a lump sum, but the vendor will claim each item separately.

FAQS

Q: Do I need to communicate with a DME vendor using encrypted email? If so, how do I do that?

A: Yes, all client specific communication with contracted providers, including DME vendors, must use the state Secure Email System.

The vendor must also communicate to you using encrypted email anytime there is client information included. If staff receive emails with client's personally identifying information, they must remind the vendor to use the secure email system. This is included in their agreement.

HCA AND DSHS HAVE BEEN WORKING WITH Vendors

Important message about denials

The ProviderOne payment system allows program policy to be enforced. DSHS is always the payer of last resort. The previous SSPS system did not have the ability to check for Managed Care, Medicare or Medicaid (Apple Health) coverage. ProviderOne has this ability and enforces the policy, requiring other options to be exhausted prior to paying the claim with the social service authorization number.

Medicare Denials

Claims may deny for clients with Medicare. If Medicare might cover the item or service, Medicare must be billed first. If Medicare denies coverage of the item or service, then social services could pay. Not all codes require verification that Medicare has denied the item or service. We will be updating our website with additional information about which codes require a Medicare denial. Additionally, we will add instructions for how to include the Medicare denial when submitting the claim.

Managed Care Denials

Some claims have denied due to Managed Care coverage. If Managed Care might cover the item or service, approval from Managed Care must be sought before the item or service is provided. If Managed Care denies coverage of the item or service, then social services could pay. If the claim is missing the authorization number or the authorization doesn't match the client ID, the managed care denial reason may appear. If you received a denial, check your claim for these items and resubmit.

There was a brief system error that caused some claims to be denied for managed care. Those claims have been reprocessed. If you have a claim that has not been reprocessed, contact the BASS team at the contact information below.

Medicaid State Plan

If a client has Medicaid State Plan (Apple Health) coverage, the client's Medicaid State Plan benefit should be billed first. If the client's Medicaid State Plan limit for the item has been reached, or if the item or service is not covered by the Medicaid State Plan benefit, then social service could pay.

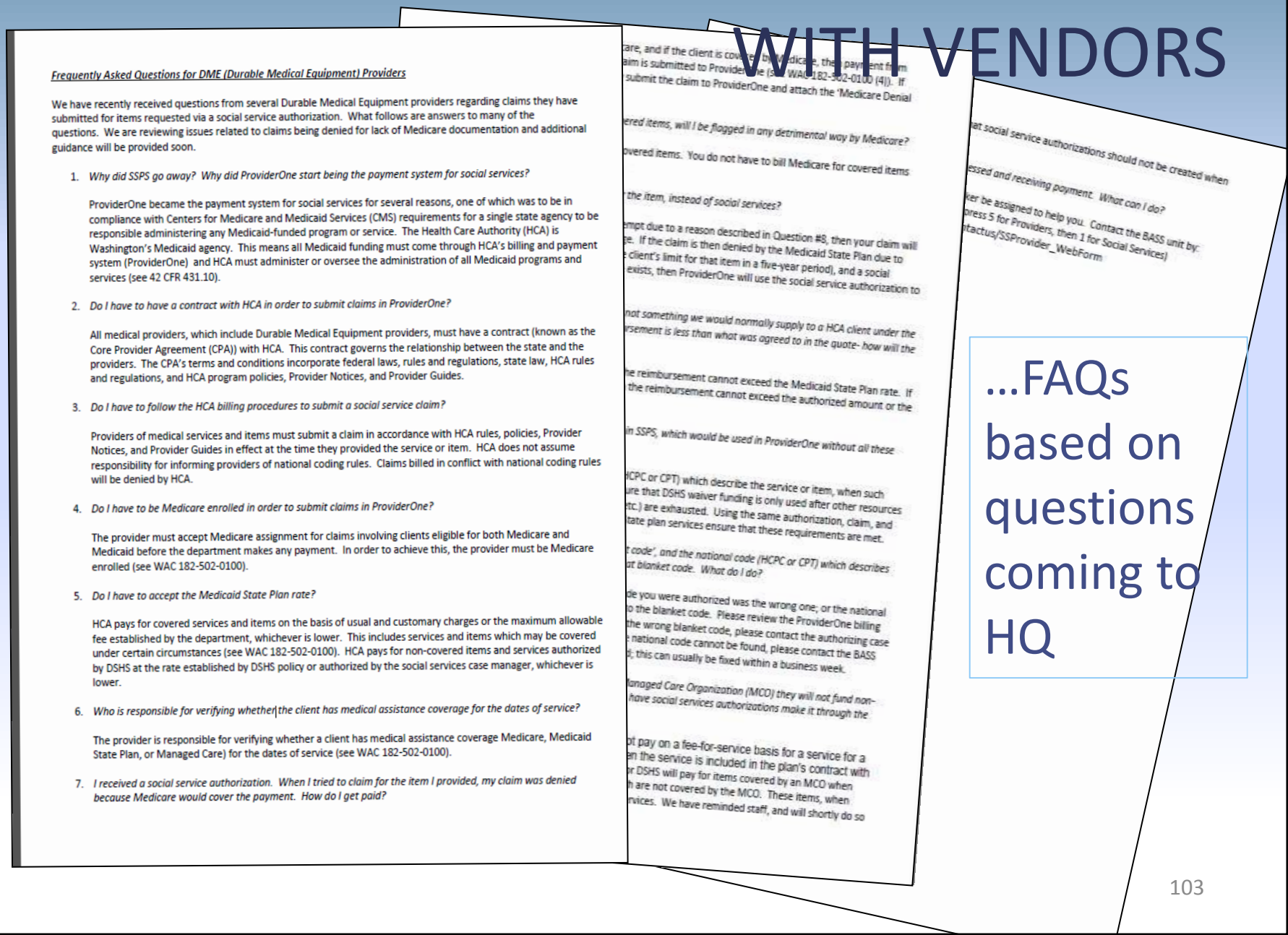
Referring Provider

DME must bill in a HIPAA compliant manner, which requires the NPI for the referring professional. Case managers and family may recommend a need, and then the appropriate professional will need to prescribe or write the order for the item. The prescribing professional's NPI is needed on the claim. A DME provider's NPI is not allowed in this field.

If you have questions about a denial or how to submit your claim, please contact the BASS team at 1-800-562-3022, after the initial messages, press 5 for Provider Services, then 1 for Social Services. Or, you can email BASS@dshs.wa.gov

Information regarding when a denial is needed...

HCA AND DSHS HAVE BEEN WORKING WITH VENDORS



Frequently Asked Questions for DME (Durable Medical Equipment) Providers

We have recently received questions from several Durable Medical Equipment providers regarding claims they have submitted for items requested via a social service authorization. What follows are answers to many of the questions. We are reviewing issues related to claims being denied for lack of Medicare documentation and additional guidance will be provided soon.

1. *Why did SSPS go away? Why did ProviderOne start being the payment system for social services?*

   ProviderOne became the payment system for social services for several reasons, one of which was to be in compliance with Centers for Medicare and Medicaid Services (CMS) requirements for a single state agency to be responsible administering any Medicaid-funded program or service. The Health Care Authority (HCA) is Washington's Medicaid agency. This means all Medicaid funding must come through HCA's billing and payment system (ProviderOne) and HCA must administer or oversee the administration of all Medicaid programs and services (see 42 CFR 431.10).

2. *Do I have to have a contract with HCA in order to submit claims in ProviderOne?*

   All medical providers, which include Durable Medical Equipment providers, must have a contract (known as the Core Provider Agreement (CPA)) with HCA. This contract governs the relationship between the state and the providers. The CPA's terms and conditions incorporate federal laws, rules and regulations, state law, HCA rules and regulations, and HCA program policies, Provider Notices, and Provider Guides.

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

   Providers of medical services and items must submit a claim in accordance with HCA rules, policies, Provider Notices, and Provider Guides in effect at the time they provided the service or item. HCA does not assume responsibility for informing providers of national coding rules. Claims billed in conflict with national coding rules will be denied by HCA.

4. *Do I have to be Medicare enrolled in order to submit claims in ProviderOne?*

   The provider must accept Medicare assignment for claims involving clients eligible for both Medicare and Medicaid before the department makes any payment. In order to achieve this, the provider must be Medicare enrolled (see WAC 182-502-0100).

5. *Do I have to accept the Medicaid State Plan rate?*

   HCA pays for covered services and items on the basis of usual and customary charges or the maximum allowable fee established by the department, whichever is lower. This includes services and items which may be covered under certain circumstances (see WAC 182-502-0100). HCA pays for non-covered items and services authorized by DSHS at the rate established by DSHS policy or authorized by the social services case manager, whichever is lower.

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

   The provider is responsible for verifying whether a client has medical assistance coverage Medicare, Medicaid State Plan, or Managed Care) for the dates of service (see WAC 182-502-0100).

7. *I received a social service authorization. When I tried to claim for the item I provided, my claim was denied because Medicare would cover the payment. How do I get paid?*

…FAQs based on questions coming to HQ

DME Billing Guide

DURABLE MEDICAL EQUIPMENT (OTHER) AND NON-CRT WHEELCHAIRS

Email Updates

Current Provider Guide

- Current Provider Guide
  (Use for dates of service on and after May 1, 2015)

Current Shared Services Supplemental Billing Guide

- Current Supplemental Billing Guide (Adobe file)
- Current Social Services Blanket Code HCPCS Code Billing Table (Excel file)
  (Use for dates of service on and after January 15, 2015)

This supplemental billing guide is for social service providers who will begin billing
payment system on January 15, 2015.

What Does the Rule (WAC) Say?

- DME Washington Administrative Code (WAC)

How Much Does the Agency Pay for Durable Medical Supplies

- Wheelchair & Accessories Fee Schedule

Where Can I Find Previous Versions of the Provider Guides?

Click on one of the following dates of services:

- July 1, 2014 - April 30, 2015 (Superseded)
- January 1, 2014 - June 30, 2014 (Superseded)
- July 1, 2013 – December 31, 2013 (Superseded)
- January 1, 2013 - June 30, 2013 (Superseded)
- September 1, 2012 - December 31, 2012 (Superseded)
- July 1, 2012 - August 31, 2012 (Superseded)
- April 1, 2012 - June 30, 2012 (Superseded)
- January 1, 2012 - March 31, 2012 (Superseded)
- August 1, 2011 - December 31, 2011 (Superseded)
- July 1, 2011 - July 31, 2011 (Superseded)
- January 1, 2011 - June 30, 2011 (Superseded)
- May 09, 2010 - December 31, 2010 (Superseded)
- February 1, 2010 - May 08, 2010 (Superseded)
- January 1, 2010 - January 31, 2010 (Superseded)

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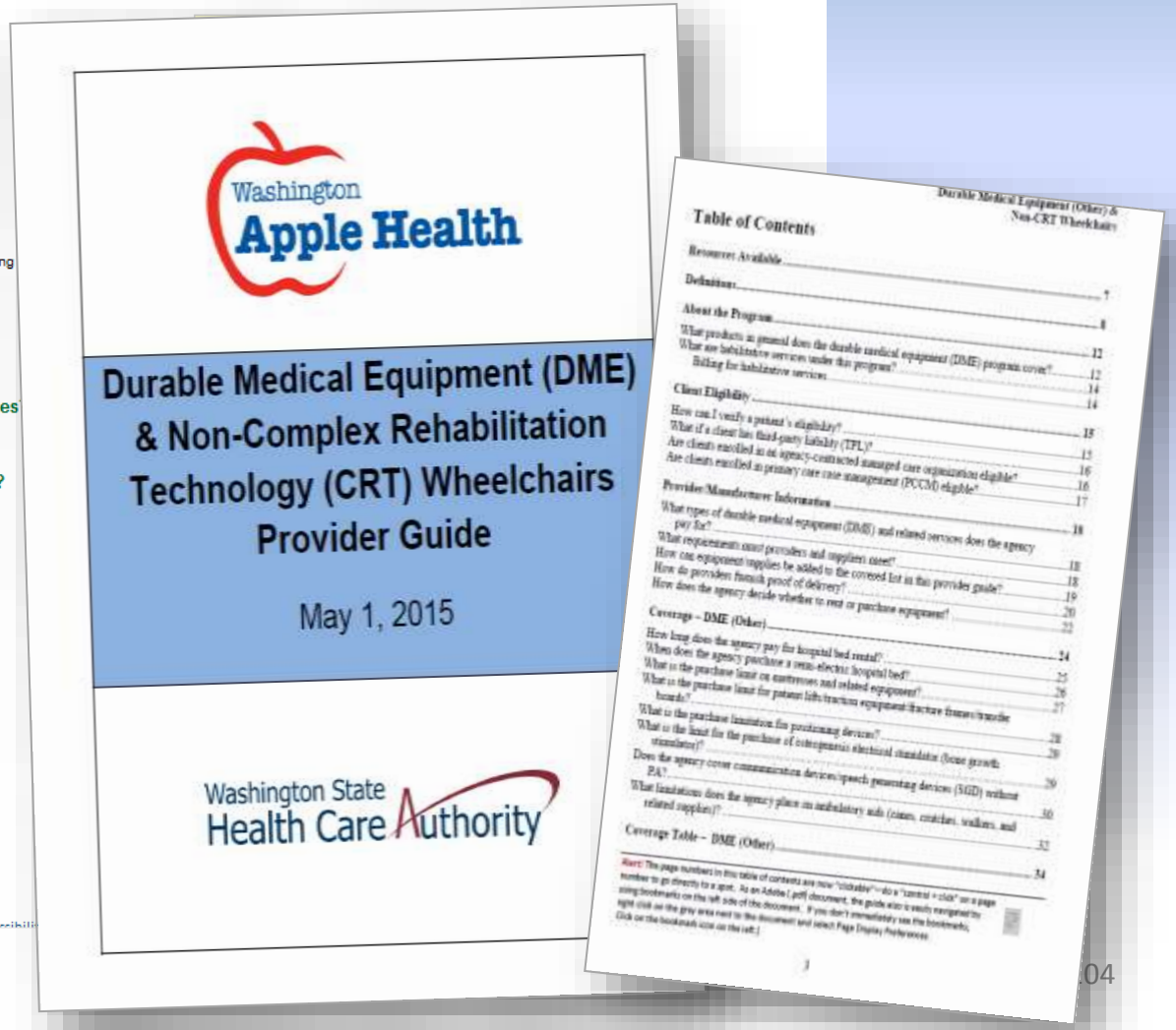

Did you know?

- There have been two webinars held with DME vendors. Some of the questions and concerns from their webinar have been incorporated in this presentation.
- System and policy-related questions that have come to HQ have been consolidated into one document and a second Q&A will be distributed to all of our DME vendors. Both will be available on the HCA website.

FAQS

Q:Is the problem with DME vendors not getting paid resolved? We have heard that even if we create the authorization correctly they are not getting paid.

A: Many vendors are getting paid, but many issues remain. Some claims are not paying due to the vendor not claiming correctly or because they are missing necessary information. Some claims are not paying because the denial process has not been followed. DSHS is working with vendors to resolve any lingering issues and confusion.

FAQS

Q: What do we do with equipment already in the middle of processing before updated rules came into effect? Start from the beginning again?

A: No. Claims for items that are “typically not covered” which, by policy, require the vendor to seek an ETR from HCA that were provided prior to 07/10/2015 were provided at a time when vendors were told an ETR was not required and so no ETR will be required up to that date. This policy was clarified with vendors during the vendor webinar held on 7/10/15. No action by case workers will be necessary for these claims to be paid.

Don't forget….

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.
- If signing the invoice, the case worker must include the statement "***Not to exceed the Medicaid reimbursement rate***" with their signature.
  - 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.
  - The provider will be paid at the Medicaid reimbursement rate or the authorized rate, whichever is lower.

Did you know?

- Until you hear differently, the BASS unit continues to be available to problem-solve and assist with claims issues. Encourage vendors to reach BASS by calling 800-562-3022 (after the short introduction, press 5 for Providers, then 1 for Social Services).

- HCA and DSHS are working together to resolve the many issues.

WHAT SHOULD CASE WORKERS DO TO ASSIST WITH THE ISSUES?

- Don't try to work around the system.
- Don't use your own credit card, the PCard, or any other card.
- Don't use the Fred Meyer, Shopko or another account.
- Don't use a CCG to make the purchase and be reimbursed.
- Don't put the equipment in someone else's name, including your own.
- Don't use an inaccurate code simply because it will "go through" with no issues.

WHAT SHOULD CASE WORKERS DO TO ASSIST WITH THE ISSUES?

Do:

- Follow the instructions outlined here and ensure other sources are used first.
- Be patient.
- Remember:
  - These regulations have always been in place.
  - There are still some issues being resolved.
  - Information will be disseminated ASAP when issues are resolved or if there is a change in process/procedure.

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 you have 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"

Did you know?

Not all items will be denied!

We have spent a lot of time talking about denials. But the fact is many items WILL be covered. This means:

- That the item your client needs will probably be obtained appropriately through their medical benefit whether it is private insurance, Medicare or Apple Health.
- Case workers will not be creating as many social services authorizations because most of the equipment necessary for our clients will meet the medical necessity requirement.

Resources

- HCA's Find a Provider List
- WAC 182-500-0070 Medically Necessary
- Important Message About DME Denials
- FAQs for DME Providers
- ProviderOne DME Provider Billing Guide
- Medicare Supplier Directory

Transforming Lives

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