Department of Human Services
Annual DME Task Force Meeting
State Capitol Judicial Wing 2nd Floor AV Room 209/210
Tuesday, October 22, 2019
1:00 – 3:00 p.m.

Medical Services General Statement: The main purpose of the Durable Medical Equipment (DME) Task Force Meeting is to be a working group to discuss current policy and to bring recommendations to the table for Medical Services to take into consideration. It is not meant to discuss individually denied cases. The Department's decisions are based on 42 CFR 440.230(d) and the North Dakota Administrative Code 75-02-02-08, which allows the Department to place appropriate limits on services based on such criteria as medical necessity or utilization control procedures.

Attendees:

Tammy Holm – DME Administrator

Tammy Zachmeier – UR Supervisor

Erik Elkins – Assistant Director of Medical Services

Caprice Knapp – Medicaid Director

Sheila Osbud – Sanford Health Care Accessories, Director of Patient Health

Sara Regner – Coding Specialist

Rachael Buckwitz – Utilization Review (UR) Nurse for Out of State (OOS)

Sue Burns Utilization Review (UR) Nurse for Out of State (OOS) -

Kira Johnson – Sanford Health, Compliance Dept.

Pat Green – Medical Director, MedQuist Home Medical, Williston

Kevin Holzer – Great Plains Rehab Services, Bismarck

Jody Anderson – Executive Director, Altru Health System

Mike Barrish - Vice President of Operations, ActivStyle

PROVIDER SUBMITTED QUESTIONS:

1. Does ND Medicaid allow a NEW "REASONABLE USEFUL LIFETIME" (RUL) SYRS/60 MONTHS for oxygen equipment/therapy? This question is in ND Medicaid Primary and Secondary claims. Per Medicare policy the RUL allows for replacement even if the equipment is functioning - allowed new RUL rental period and payment of 36 months / 3 yrs. North Dakota Medicaid Service Auth's are currently being denied if there is no information that the equipment is no longer functioning.

   In accordance or referencing the DME Task Force meeting on 06/29/2011 - the Question was asked and answered - ND Medicaid follows Medicare policy for oxygen equipment and supplies and will therefore IMPLEMENT the NEW RUL policy.

   Oxygen Service Auth's had been previously approved for the full 36 months/3 yrs. with a new RX and a physician visit within 60 days. Currently, Service Auth's are approved for 12 months/1 yr., so providers are required to send renewal Service Auth's yearly. See Attachment 1

ND Medicaid's response: The Department agreed to follow Medicare's rental guidelines for dual eligible members. The Department will continue to follow established Medicare 36-month rental cap

as outlined by Medicare rules for dual eligible members. For example, once the 36-month rental cap starts, Medicare recertification and maintenance rules apply, and the department will follow:

Medicare allows rental of oxygen equipment for a total of 36 months and then does not allow DME providers to submit service authorizations or a bill for the next 24 months. During the five-year period, Medicare requires a member to recertify annually to ensure the member still meets coverage criteria. N.D. Medicaid mirrors Medicare as also requires annual oxygen recertification, which the member needs to be seen by the practitioner. This visit allows the practitioner to examine and doing the O2 stats testing to determine if the member needs to continue using oxygen. If the member needs to continue oxygen, a new prescription is issued, as it is only valid for a year and a new CMN.

North Dakota Medicaid will not be following the Medicare 36-month cap policy on oxygen for Medicaid-only members.

2. Infusion Pump Supplies - Per policy: External Infusion Pump - see attached; It states that A4221, A4222 and K0552 are all covered Infusion Pump supplies. They are also listed on the DME fee scheduled. When submitting these for payment they are stating they are not covered and the codes must be "S" codes, however "S" codes are not on the DME fee schedule. Please provide clarification.

   N.D. Medicaid Response: This meeting is not intended to discuss individual situation-specific denials; instead can the provider who asked this question please send Tammy Holm the denied service authorization numbers so it can be reviewed, and guidance can be given. After review of the individual case, if the answer would universally benefit all other providers, the answer and applicable guidance will be added to this question.

3. Why do we have to rent equipment (such as an enteral pump) when it is a replacement? The policy does not state that the equipment must be rented.

   North Dakota Response: The Department reserves the right to determine when primary to rent or purchase based on a case by case review. Rental is preferred as during rental period as the provider is responsible for repairs and any related supplies.

4. Why is it up to a provider to eat the extra days on a Bili Light if a patient needs it longer than 7 days?

   North Dakota Medicaid Response: Usually an infant doesn't require a bilirubin light longer then the allowed 7 days after discharge. If the member has other medical conditions that cause addition days, the provider can submit with supporting medical documentation to support for review on a case by case basis. Provider please email Tammy Holm the number of requests you receive requiring more than the 7 days allowed so the Department can review this request further.

5. Why does MA require a 60/day office visit for all equipment including CPAP when other insurances are all 6 months or a year?

North Dakota Medicaid Response: The Department has considered this policy and is revising the DME manual to allow 90 days which will allow more time for members to be seen by their practitioner and DME providers additional time to obtain required documents.

6. Our sleep lab schedules out at least 2 to 3 months for patients to get the studies done. Therefore, if the patient qualifies for CPAP the prescription is beyond the 60-day window. Physicians contact the patients via phone with the results of the study.

   North Dakota Medicaid Response: Provider do you mean the Dr. note is beyond 60 days, because the Dr. note needs to be within 60 days of the service auth. start date not a prescription as it is valid for a year. A member needs to be seen by their prescribing practitioner for follow-up to discuss with the member the importance of use and how non-compliance can potentially affect their health.

7. Why do we need to have directions for use on the prescription if it is in the medical documentation? Physicians do not know how to answer the question when requested.

   North Dakota Medicaid Response: The DME Manual prescription section will be revised to clarify that the "direction of use" element is required for all non-equipment items. It will also include an example when the "direction of use" element is needed.

8. Late last winter the ND Providers were asked to review and provide comments on a new revised/updated DME policy manual. As of today, we have not received an update on when this will be released. Can you provide?

   North Dakota Medicaid Response: The Department has reviewed and taken into consideration the provider's suggestions and is currently in the process of finalizing the DME Manual revisions. The revised and updated manual and the Department's responses to the provider's comments will be posted very soon.

9. Last spring the MAMES DME Providers worked with the Dept. and ND Legislators to pass HB 1115. This becomes law on 1/1/20. The bill addressed our dual recipient patients and products/services that are covered by Medicare and Medicaid. The regulation stipulated additional documentation such as prior authorization, or additional prescription requirements would no longer be required by the state, and that Medicare required documentation would suffice for all. Can you please tell us how this will be implemented?

   North Dakota Medicaid Response: The Department will be posting guidance for providers on the Provider's Update webpage when finalized.

10. Why does ND Medicaid require "instructions for use" on all DME items rather than for drugs or specific DME which have a scheduled regimen? The medical necessity is established in the medical record, thus directions for use are evident. An example is an injury or surgery where an orthotic brace, walker or cane is needed for stabilization/ambulation which the DME supplier would be instructing the patient on use at the time of delivery. When I asked what ND Medicaid would be looking for, I was told that the provider should write "needed for ambulation" on the order. Requiring this on an order doesn't make sense and is asking

providers to do more work than is necessary. CMS is working towards putting patients over paperwork and this is a prime example where this can be achieved. We ask that you only require directions for usage with DME items and drugs that are on a specific regimen (i.e., dose or concentration, route of administration, frequency of use) as Medicare follows.

North Dakota Medicaid Response: The DME Manual prescription section will be revised to clarify that the "direction of use" element is required for all non-equipment items. It will also include an example when the "direction of use" element is needed.

11. What is ND Medicaid's process for deciding which HCPCS codes are added to the annual DME Fee Schedule? We have noticed that established HCPCS codes for Off-the-Shelf Orthotics are not included which are frequently provided and billed for. We requested these codes be added so services aren't denied, delayed in processing and are paid appropriately. Shouldn't all valid HCPCS codes be assessed annually and included in the fee schedule?

    North Dakota Medicaid Response: When Medicare adds a code to their fee schedule does not guarantee the Department will add them as well. Updated codes are reviewed and added to the fee schedule if deemed appropriate.

    Providers can request codes to the Department by emailing Tammy with the code and the reason it should be considered to be added to the price file along with the Medicare allowable. If the request is for something very unique, an upgrade to an existing HCPCS code, or is considered new technology, then the SFN 905 would need to be submitted. If the request is for an item similar to an item, currently covered but would have significant financial impact then the SFN 905 would also need to be submitted.

12. Medicare and all other insurances cover the power recline option on power wheelchairs if it aids in their daily cares, such as positioning, catheterization, etc. NDMA doesn't cover it if the client has care in the home, however this feature can help the caregiver complete the cares without having to transfer the person to a different surface. There is no such thing as a manual recline on a Power Wheelchair. Are there exceptions to this?

    North Dakota Medicaid Response: The caregiver is available to assist with weight shifts, help with transfer between the bed and chair and perform cares such as catheterizing or toileting as needed. To ensure funding requirements are met, items covered by the Department must be: Reasonable and necessary in amount, duration and scope to achieve their purpose, the most economical and efficacious available to fulfill the BASIC medical need, ordered by a practitioner, covered only for members who reside at home, and dispensed as quickly as possible due to the medical necessity identified for an item.

13. The 60-day rule is causing patients to have to go back to their physician for unnecessary visits. Example – Pediatric patient regularly sees PT, recommended by the physician. Therapist recommends a gait trainer and writes the medical justification and the physician signs off on it and then write the prescription. Now, the patient has to go back to the physician anyway just so the physician can state in a note "needs gait trainer". Could the physician concurring to the therapist recommendation serve as the face to face visit instead of requiring a new doctor appointment?

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North Dakota Medicaid Response: The Department understands that in some instances this may be acceptable, but due to Medicare's prior authorization requirement for many DME items the Department will continue to require the practitioner note. If the member was seen July 1st by their practitioner, and on August 1st PT sees the member AFO is getting too small and they contact the physician stating this and the physician orders a new one, it would be acceptable for the physician to add an addendum to the July 1st note to support the need.

PRIOR AUTHORIZATION QUESTIONS

1. According to the DME ND Medicaid provider manual - Providers are allowed to send a post-approval - service auth request no LATER than 90 days from the date of service or when the item was provided this is on page 20. Service auth's are being DENIED when the RX and office visit are not within 60 days of the request of the service auth start date. WHY? See Attachment 2

   North Dakota Medicaid Response: This question is related individually denied cases. Provider please email Tammy Holm with service numbers for further assistance.

2. Denials: When calling to check on why a PAR is denied would it be possible to receive all the denial reasons so the PAR can be fixed all at once? Often only one denial is identified, the issue is resolved resent and a couple weeks later another denial is identified. This can delay the dispensing of equipment by weeks.

   North Dakota Medicaid Response: The North Dakota Call Center uses the service authorization notification letter notes for reference when addressing prior authorization denial inquiries. This notification letter is also sent to both the member and provider. The authorization letter lists all denial reasons known at the time of the review. It is possible when the provider resubmits the service authorization for reconsideration there is an edit further along in the adjudication process that was not known at the time of the initial denial. The Department strives to list all the reasons for denial that are known at the time, as it is also in the Department's best interest to eliminate any duplicate processes and inefficiencies. However, sometimes it is impossible to identify all the possible reasons a denial may occur when those triggers may be located further down the prior authorization adjudication progression.

3. We have received denials for parts on a wheelchair that the primary insurance pays for, but NDMA doesn't. Instead of denying the part, NDMA denies the whole chair. Is it possible to just deny the accessories that NDMA doesn't cover?

   North Dakota Medicaid Response: When non-covered items are submitted the Department will need to deny the entire request for the following reasons:

   - **Providers are to review the wheelchair policy and the fee schedule before submitting service authorization requests to ensure items are covered as items not covered should not be requested.**

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- **Miscellaneous codes such as 'K0108' may list multiple items with a total dollar amount that cannot be separated out to approve for the covered items only. For example: the request may include a transit option, joystick cover, and clothing guard. The 'K0108' will be denied as we are not able to just approve just the first two items on the request as the requested dollar amount can't be revised on the request.**

- **Previously, providers requested that the entire service auth. request be denied as they would rather use the 'copy' function button and resubmit for only covered items and only have one service authorization number instead of multiple numbers. The Department will continue to deny the entire request with instructions to the provider that they should review the fee schedule to determine what HCPCS codes that are covered and to submit a service authorization request for covered-only codes, including only the power components that are required to operate the power wheelchair covered codes.**

4. Can notes from a Physical Therapist that have been signed by a MD be used for prior authorization for Orthotic and Prosthetic devices? ND Medicaid has allowed this in the past and claims were covered, but we have seen some claims currently denied. Since the MD has signed the PT note, is there a reason why this documentation cannot be used and why is there inconsistency?

   North Dakota Medicaid Response: Sent email to the submitted provider for clarification to see if SA or Claims denial. Provider replied it was only one but could not remember who the member was or the related SA number. Shared with provider if issues happen again to contact Tammy Holm for assistance.

5. ND Medicaid is denying orthotic claims (for children and young adults) submitted with ICD-10 diagnosis code Q66.6 (Other congenital valgus deformities of feet) stating that this diagnosis is for flat feet. The correct diagnosis code for flat feet is M21.4 (Flat foot [pes planus] (acquired). We are correctly reporting the diagnosis for the condition the patient has been diagnosed with under M21.1. Is this a misunderstanding of the ICD-10 codes or what is the rationale for this decision.

   North Dakota Medicaid Response: The Department's review process consists of evaluating the submitted diagnosis code(s) and all attached supporting documents with the service authorization. The approval or denial of the service authorization is contingent upon the prescribing practitioner's visit/exam documentation and a determination if the member's condition meets the related policy coverage criteria. An approval or denial is not based on a diagnosis code alone, but rather both the diagnose and submitted documentation to ensure policy coverage criteria is met.

   The Department has had the Medical Consultant review several of the denied requests. All the submitted documentation used in the original denial was reviewed and the medical consultant agreed with the denial as it showed the member had flat feet, which the policy states is not covered.

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MMIS QUESTIONS

1. PCP Issue with EOD Visits: MMIS is not recognizing these claims when we are entering the Place of Service as "ER" (23) & using the ER doctor's NPI #...these claims are also being adjusted by NOMA staff upon receiving emails to MMISinfo.gov. Could we get a timeline on when these will be corrected?

   North Dakota Medicaid Response: Alyssa Neis reached out to Barb Stockert for examples for her to review for both questions 1 and 2.

2. PCP Issue with Breast Pumps: When ordered by an OB/GYN, the process is to enter that OB/GYN doctor's NPI # in MMIS, since PCP is exempt in such cases. MMIS is to recognize the doctor's specialty based on this NPI entered...this process did work previously; however, currently MMIS is not recognizing this & we are emailing MMISinfo.gov & these claims are being adjusted. Could we get a timeline on when these will be corrected?

ADDITIONAL INFORMATION

The purpose of the CMN is to be a quick reference guide to policy criteria (a user aid), not a replacement for required medical documentation or a required prescription. The CMN is not an all-inclusive guide for NDMA coverage criteria. Therefore, it is not considered a replacement for medical documentation.

NDMA has been flexible in allowing physicians to utilize a CMN of their preference, which will at times require additional medical documentation to support medical necessity.

NDMA is experiencing an increase in incomplete CMNs: sections not addressed, missing physician signature and/or not dated. This required information will result in the service authorization being denied, which delays the process.

The Department has been receiving CMNs that have been modified by the providers (*see example below*).

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1. Date of Polysomnogram: 4/26/16 (Polysomnogram required for all CPAP requests)	
2. If request is for BIPAP, explanation of the inability to tolerate CPAP:	
3. Results of Sleep Study: severe deg of sleep disordered breathing	Obstructive Apneas:
AHI:	Lowest Oxygen Saturation: 87%
Sleep Time: 173 mins	Total Apneas: 5 pre tx 2 post tx
4. If prescribed for central sleep apnea, fill out this section.	
Central apneas/hr: Hours	Longest central apnea: Hours

SECTION C - Narrative Description

Narrative description of ALL items, accessories and options etc.: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included in the attached document).

E0601 - CPAP - Rental $138.00 mo
E0562 - Humidifier - Rental $45.00 mo

Length of Need: 99 (months) Diagnosis: G47.33

PAP SUPPLIES: PURCHASE
A7027 ORAL/NASAL MASK - 1 PER 6 MONTHS
A7028 REPLACEMENT ORAL/NASAL CUSHION - 2 PER MONTH
A7029 REPLACEMENT ORAL/NASAL PILLOW - 2 PER MONTH
A7030 FULL FACE MASK - 1 PER 6 MONTHS
A7031 REPLACEMENT INTERFACE FOR FULL FACE MASK - 1 PER MONTH
A7032 REPLACEMENT NASAL MASK CUSHION - 2 PER MONTH
A7033 REPLACEMENT NASAL MASK PILLOW - 2 PER MONTH
A7034 NASAL MASK - 1 PER 6 MONTHS
A7035 HEADGEAR - 1 PER 6 MONTHS
A7036 CHIN STRAP USED NASAL/FULL FACE MASKS - 1 PER 6 MONTHS
A7037 TUBING USED W/ PAP DEVICE - 1 PER MONTH
A7038 DISPOSABLE FILTER USED W/ PAP DEVICE - 2 PER MONTH
A7039 NON-DISPOSABLE FILTER USED W/ PAP DEVICE - 1 PER 6 MONTHS
A7046 REPLACEMENT WATER CHAMBER FOR HUMIDIFIER - 1 PER 6 MONTHS

MEDICAL NECESSITY: Treatment of OSA

CMN's for enteral products must have the units listed to prevent a denial.

3. Print product name(s).	
4. Total number of units per month.	
5. Will this consist of 51% or more ☐ Yes ☐ No	B4154 Products Only: Will this consist of ☐ Yes ☐ No

Units are considered "per month". For example, on the service authorization if the dates of service are for a year (12 months), the requested units need to be for 12 months as well. For example; Dr. orders 450 units per month for a year. 12 months x 450 units per month = 5400 units. This is the total to be entered on the service authorization request.

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- **PT, OT, Orthotist, or Prosthetist notes are considered supporting documents, but cannot be considered as a substitute for the required Dr. exam notes.**

- **The following list contains reason codes available when you check the status of your SA on the web portal.**

  A1 – Certified in total –all items requested were approved as requested

  A2 – Certified – Partial – not all items were approved

  A3 – Not Certified – SA denied

  A4 – Pended- waiting to be reviewed

  A6 – Modified – all items requested approved but not approved as requested. Example; labor units requested is 8 but only 6 was approved.

Please remember to include on the SA notes section (see yellow highlighted section below) equipment date of purchase, equipment purchased prior to enter to nursing home, insurance information, reason for early equipment replacement, or any information the provider feels will assist during the review.

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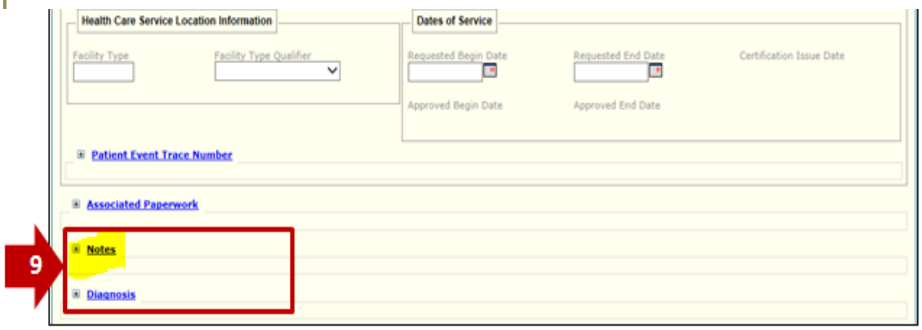

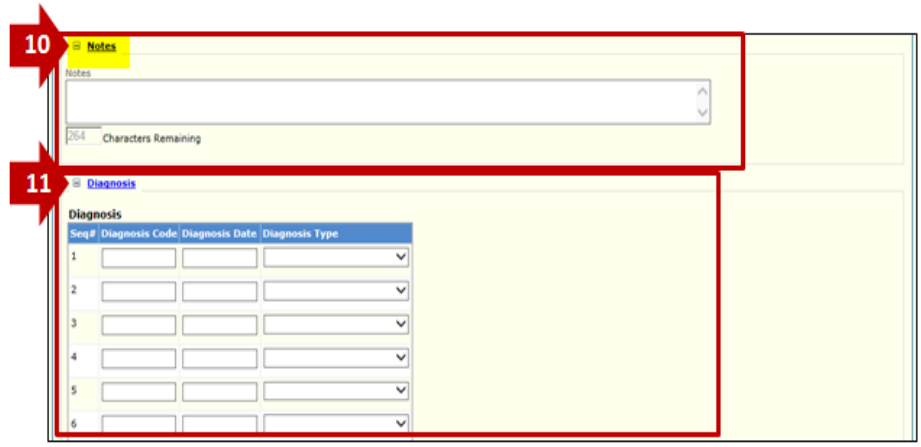

9. **Notes** and **Diagnosis** are expandable sections that you use to provide additional information to support your request.

   Click **+** to open the **Notes** and **Diagnosis** sections.

10. Use **Notes** to provide any **required** information that you previously included on the paper SA form, including:
    - Equipment date of purchase
    - Equipment purchased prior to entering nursing home
    - All insurances, if Medicaid is not the primary insurer
    - Reasons for requesting early equipment replacement
    - PLUS, any information that will help the reviewer processing the SA

After completing your notes, click **Save** at the bottom of the page/screen.

- **The Department reminds providers to check Medicaid Provider's Updated web page for important updates regarding policy changes, billing and coding guidance etc.**

  http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-updates.html

- **When entering information on the Service Line Item only the Service Code from is required. Please do not utilize the Service Code too as it is not necessary for DME requests.**

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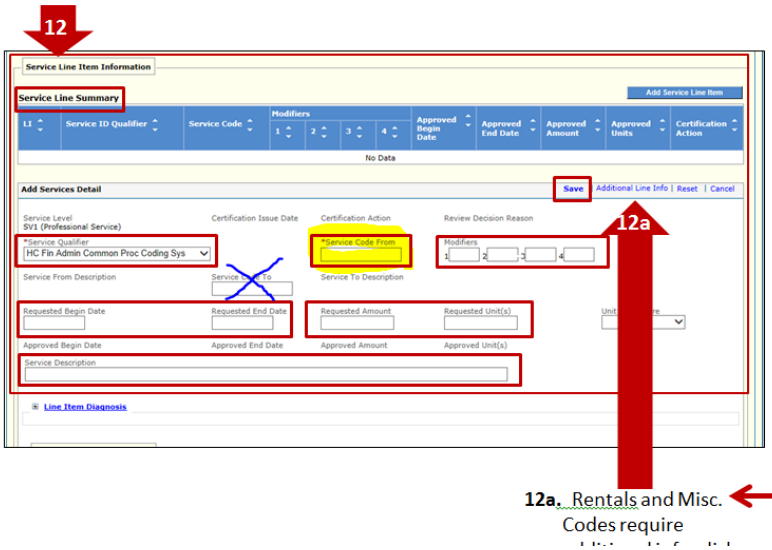

11. Use **Diagnosis** to enter the diagnoses related to the SA. After completing, click **Save** at the bottom of the page/screen.

12. **Service Line Item Information** section is already open and the following fields are required under **Add Services Detail**, including:

- **Service Qualifier**
- **Service Code From**
- **Modifiers** (e.g. RR for rental)
- **Requested Begin Date** and **Requested End Date**
- **Requested Amount** and/or **Requested Unit(s)**
- **Service Description** when SA uses a Misc. Code (e.g. K0108 used for items that require quantities greater than one)

Click **Save** in the right corner, the

The Department would like to thank providers for their continued services and dedication that they provide for our NDMA members.