DOH Medicaid Update March 2007 Vol. 22, No. 3

Durable Medical Equipment
Provided to Assisted Living Program Participants

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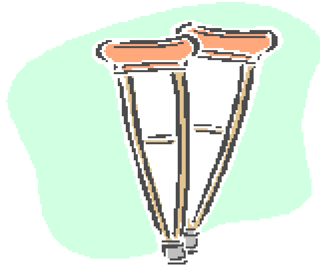
The Department of Health and Human Services Office of Inspector General recently conducted an audit of Durable Medical Equipment (DME) Providers Medicaid claims for Assisted Living Program (ALP) participants. Their review identified that some DME providers have inappropriately billed Medicaid for certain DME and supplies provided to ALP participants.

The ALP operates in adult homes and enriched housing programs and provides a combination of residential services and home care services to Medicaid and private pay residents. For each Medicaid enrollee participating in the ALP, a daily rate is paid to the ALP for the provision of nine home care services, including the provision of medical supplies and equipment *not requiring prior approval.*

ALP payment regulation at Title 18 NYCRR (New York Code of Rules and Regulations) 505.35 (h) states that the Medicaid capitated daily rate is payment in full for the nine covered services.

Department regulation at Title 18 NYCRR 505.5 (d)(1)(iii), governing the provision of DME, additionally states that "Payment will not be made for items provided by a facility or organization when the cost of these items is included in the rate." **Consequently, DME providers may only submit claims for a Medicaid eligible ALP participant for DME items requiring prior approval.**

Procedure codes that require prior approval are underlined in the DME fee schedule, available at http://www.emedny.org/ProviderManuals/DME/PDFS/DME_Fee_Schedule_2006.pdf



DME providers should work with adult homes and enriched housing programs who operate an ALP and with whom they do business, to establish procedures that will assure appropriate claiming of DME for Medicaid eligible ALP residents.

Questions regarding this article may be directed to the Bureau of Long Term Care at (518) 474-5271.

Emergency Procedures for Durable Medical Equipment Requiring Prior Approval

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The following procedures will be available to Durable Medical Equipment (DME) providers for dates of service on and after January 23, 2006, for emergency situations in lieu of requesting normal prior approval. Following the procedures described below, *you will be able to bypass the prior approval requirement when an emergency situation occurs.*

Definition:

An emergency medical condition (for Medicaid) is defined in 42 CFR 440.255(c) as:

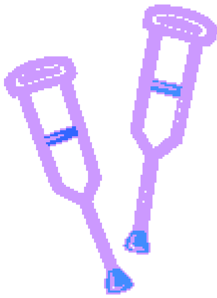
a medical condition...manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Only a qualified ordering practitioner may determine, using his or her professional judgment, whether a situation constitutes an emergency. *The ordering practitioner's documentation of the specific need for emergency must be maintained in the patient records of the ordering practitioner and DME provider, along with the fiscal order.* **In such emergency situations, prior approval is not required.**

Process to Bypass Prior Approval:

DME providers must indicate the service is of an emergency nature by using the Emergency Indicator on the paper claim form [Box 16a on the paper Claim Form 150001] or electronic claim [Loop 2400, SV109 of the 837P].

There are several different situations which may occur:



- The service requiring prior approval has a HCPCS procedure code and price identified in the DME Fee Schedule;
- The service requiring prior approval has a HCPCS procedure code but there is no price identified in the DME Fee Schedule;
- There is no HCPCS procedure code that identifies the service;
- The service is a repair of an item with a HCPCS code and price; or
- The service is a repair of an item without a HCPCS code or price.

1. For DME services that have a **HCPCS procedure code and a price on file:**

- Indicate emergency by completing the Emergency Indicator field on either the paper or the electronic claim form.
- The claim will bypass the PA requirement and pay the amount on file.

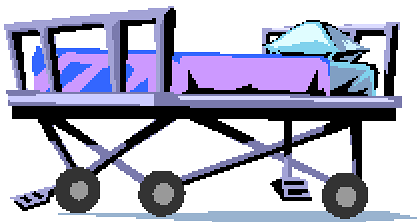
2. For DME services that have a **HCPCS procedure code but no price identified** on the DME Fee Schedule (the Price column reads PA) the claim must be submitted on paper and must include the vendor invoices to support the claim as attachments:

- Indicate emergency by completing the Emergency Indicator field on the paper claim form.
- The claim will bypass the PA requirement and pend for Edit 00126 [AMOUNT CHARGED OVER SCREEN PRICE; REQUIRES MANUAL PRICING (DOH)] for manual pricing. The vendor invoice information will be used to price the claim.

3. For equipment with **no HCPCS procedure code** to identify the service - see 'Exceptions' below.

4. For emergency **repairs on equipment with a HCPCS procedure code and price** on file:

- Indicate emergency by completing the Emergency Indicator field on either the paper or the electronic claim form.
- Use the appropriate HCPCS procedure code with the modifier **"-RP".**
- **The claim will bypass the PA requirement.**



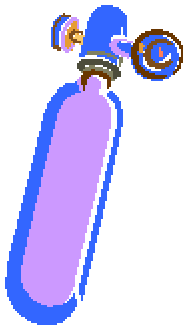
5. For repairs on equipment which have **no HCPCS code or no price** listed in the *DME Fee Schedule:*

- Indicate emergency by completing the Emergency Indicator field on either the paper or the electronic claim form.
- Use procedure code A9900 on the claim but without modifier "-RP".
  The fee for A9900 has been increased to $250, effective for dates of service on and after January 23, 2006. Claims with the Emergency Indicator will pay up to $250 without prior authorization.

- If the charge for emergency A9900 repairs is greater than $250, the claim **must be submitted on paper with an attached itemized invoice.** The claim will bypass the PA requirement and pend for Edit 00126 [AMOUNT CHARGED OVER SCREEN PRICE; REQUIRES MANUAL PRICING (DOH)] for manual pricing based. Providers will be paid actual acquisition cost by manufacturer's invoice plus 50%. Acquisition cost is net any discounts and does not include mailing, shipping, handling, insurance costs or any sales tax.

If a prior approval is subsequently requested for non-emergency repairs on equipment previously repaired on an emergency basis by the same provider, the provider must supply the emergency repair fiscal order and practitioner documentation of need with the current prior approval request.

DVS



Urgent supply and respiratory items are available through the Dispensing Validation System (DVS) and do not require prior approval.

Rental:

Rental of acceptable alternatives is available to address the urgent needs of clients awaiting receipt of specific items of DME otherwise requiring prior approval.

Exceptions:

This process **cannot** be utilized for initial purchase of items using the miscellaneous services code, E1399 or K0108, or where an otherwise approved code does not exist. The Department must be assured that any item being claimed using these codes is federally reimbursable.

Auditing:

As with all Medicaid services, the use of the emergency process, in lieu of prior approval, will be periodically reviewed and audited.

Any questions on the above can be addressed to CSC at (800) 343-9000.