Durable Medical Equipment

Information for Order/Referring/Prescribing (ORP) Providers

Update 2019

Presented by KEPRO

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
MEDICAL SERVICES

Prior Authorization

- All requests for Medicaid members not enrolled in a Managed Care Organization (MCO) for covered services requiring prior authorization must be submitted to the Utilization Management Contractor (UMC), KEPRO, for medical necessity determination.
- Before submitting prior authorization, be sure to check for Member enrollment status with Molina at https://www.wvmmis.com/default.aspx and check the Master Code list (MCL) at http://www.wvaso.kepro.com/ to see if the code requires prior authorization.
  - Just because a code is not listed in the MCL does not mean it is covered.
  - Covered and non-covered codes can be found at http://www.dhhr.wv.gov/bms/Pages/Manuals.aspx
- Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual, or other medical appropriateness criteria approved by the Bureau for Medical Services (BMS), is utilized for reviewing medical necessity of services requested.

Prior Authorization (Continued)

- A face-to-face encounter justifying the medical necessity and a written order by the prescribing practitioner for the DMEPOS services requested is required. Documentation must be maintained for a minimum of five years and must be made available to BMS or its designee upon request.
- Retrospective authorization is available by the UMC in the following circumstances:
  - A procedure/service denied by the member's primary payer, providing all requirements for the primary payer have been followed, including appeal processes; or
  - Retroactive West Virginia Medicaid eligibility.

What is Medical Necessity?

Medical necessity is defined as accepted health care services and supplies provided by health care entities appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.

WV Medicaid Provider Manual Section 506.1

Medical Necessity is services and supplies that are:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of an illness
- Provided for the diagnosis or direct care of an illness
- Within the standards of good practice
- Not primarily for the convenience of the plan member, caregiver, or the provider
- The most efficient and cost effective services or supplies to meet the member's need

Prescribing Practitioners

WV Medicaid Provider Manual Section Chapter 506.2

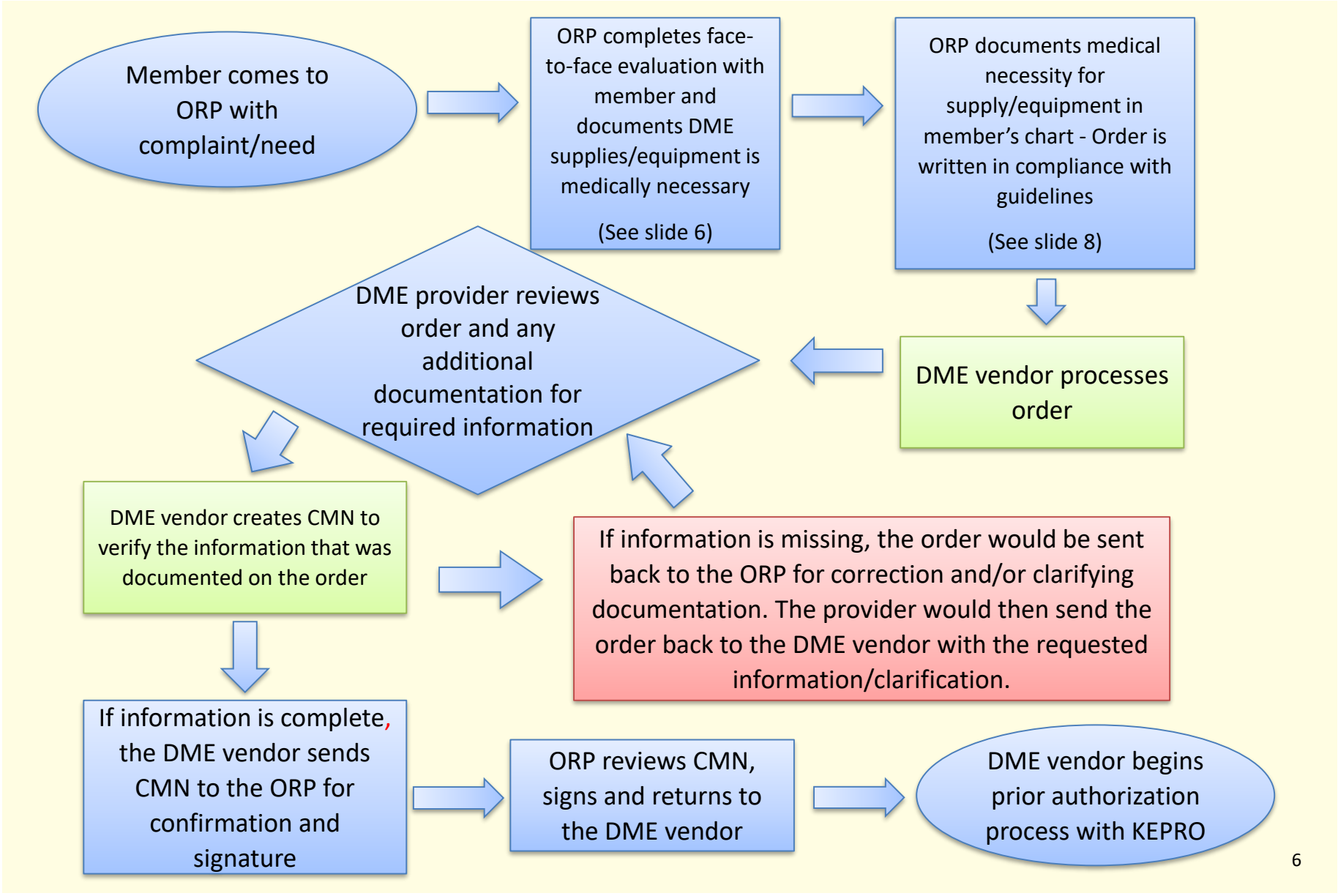
Prescribing Practitioners are enrolled physicians (MD or DO), podiatrists (DPM), advanced practice registered nurses (APRN), clinical nurse specialists (CNS), or physician assistants (PA).

Practitioners must:

- Verify member eligibility
- Provide face-to-face encounter(s) with a documented visit within the past six months
- Provide the initial order for DMEPOS to the DMEPOS provider within 30 days of the encounter and
- Submit pertinent clinical documentation for DMEPOS services requiring prior authorization to BMS' UMC for review.

Note: The practitioner may complete a mobility evaluation OR may refer the member to an enrolled licensed/certified medical professional such as a physical or occupational therapist who has experience and training in mobility evaluation. A therapist evaluation cannot take the place of the practitioner's examination.

Order/CMN Process



Face-to-Face

WV Medicaid Provider Manual Section 506.3

If the face-to-face encounter documentation does not include information supporting that the member was evaluated or treated for a condition that supports the item(s) of DME ordered, the request will be denied. When conducting a review of a covered DME item ordered by a PA, NP, or CNS, the UMC contractor shall verify that a physician (MD or DO) documented the occurrence of a face-to-face encounter by signing/co-signing and dating the pertinent portion of the medical record indicating the occurrence of a face-to-face. If this information is not included, the request will be denied.

- **The face-to-face is the responsibility of the Ordering, Referring, Prescribing (ORP) to perform and document in their record. It and/or other necessary documentation must be sent to the DME vendor in order to prepare the certificate of medical necessity (CMN)**
- The DME provider determines the specific member needs, performs any necessary assessments (mobility evaluation/home visit) to clarify specific needs and prepares CMN from the order.
- The physician's signature is required on the CMN to carry out the written order/prescription.
- The CMN should be specific and clarify the order where necessary but MUST correspond to the order/prescription.
- If there is a question regarding clinical need, medical appropriateness or ANY clinical issue, the review staff will contact the physician's office for further documentation.
  - If the missing information directly correlates to the DME equipment (type of equipment, make, model, pricing, etc.), the DME vendor will be contacted by the review staff.

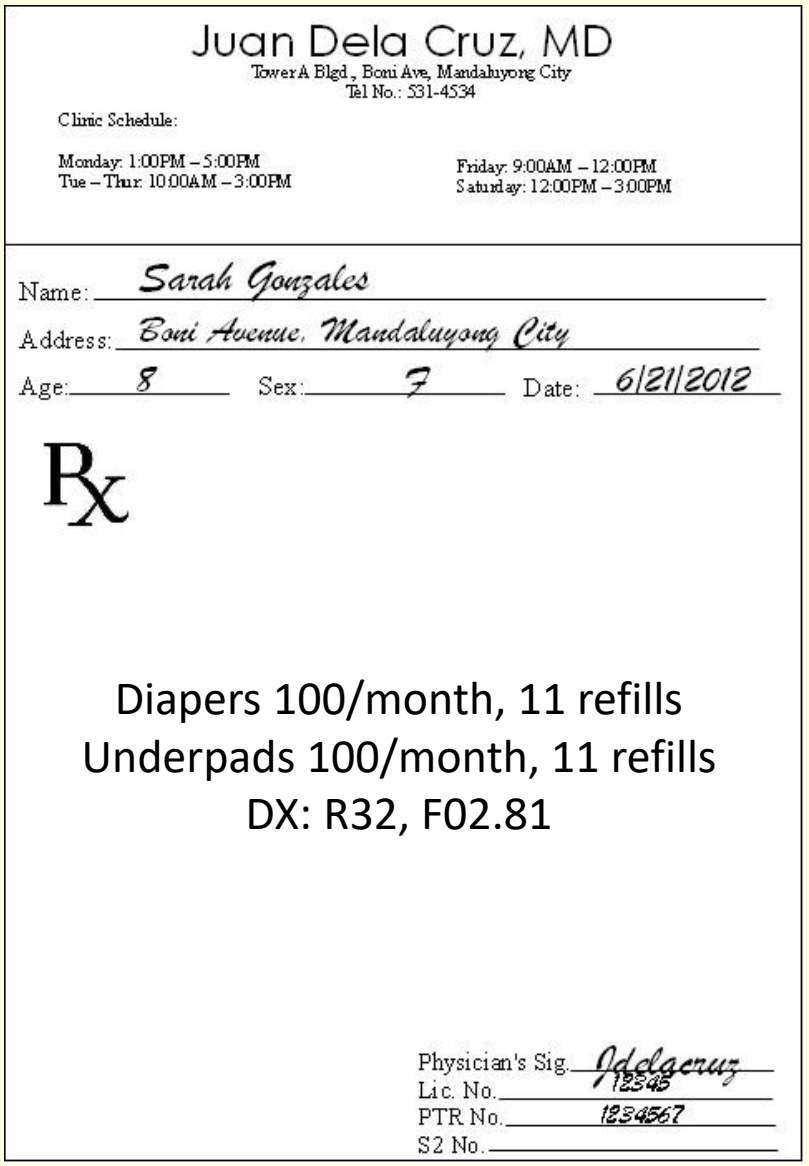
Incontinence Supplies

- Initial requests for incontinence supplies require a prescription in addition to the CMN, per Chapter 506 Durable Medical Equipment (DMEPOS).
  - A CMN is written confirmation by the DME provider to verify the information that was written on the order. The CMN does not take the place of an order.
  - A diagnosis of incontinence is required as well as any secondary diagnosis that may support the etiology of the incontinence.
    - Specifically, if the diagnosis is listed as a symptom that does not indicate the cause and/or is not definitive for incontinence, additional clinical documentation must be provided to justify medical necessity (e.g. Diabetes or IDD).
- WV Medicaid Provider Chapter 506 was updated January 01, 2016. The policy and the manual have not changed but we recently revised our procedures for medical necessity review to ensure alignment with the manual.

What information does the prescription/order require?

The prescription/order must include:

- Physician Name
- Physician Address
- Physician Telephone Number
- Specific item being ordered
- Quantity/Amount to dispense per day/month
- Diagnosis
- Length of time
  - Please Note: Orders are only considered valid for 1 year, even if the order is written for 99 months.
  - Service end date for approved prior authorizations will not be extended past the expiration date of the order.
- Date the order was signed
- Must be on physicians prescription or letterhead.



Juan Dela Cruz, MD
Tower A Bldg., Boni Ave, Mandaluyong City
Tel No.: 531-4534

Clinic Schedule:

Monday: 1:00PM – 5:00PM
Tue – Thur: 10:00AM – 3:00PM
Friday: 9:00AM – 12:00PM
Saturday: 12:00PM – 3:00PM

Name: Sarah Gonzales
Address: Boni Avenue, Mandaluyong City
Age: 8 Sex: F Date: 6/21/2012

℞

Diapers 100/month, 11 refills
Underpads 100/month, 11 refills
DX: R32, F02.81

Physician's Sig. Jddlgcruz
Lic. No. 12345
PTR No. 1234567
S2 No.

What does the prescription require? (Continued)

- The prescription must have a clearly written date.
- The quantity or frequency must not be altered or changed in any way.
- The amount needs to match the CMN.
- The prescription must be signed by the same physician that signed the CMN.
- It must be clear on the prescription what is being ordered.
  - Example: Instead of indicating on order *"incontinence supplies",* be specific and specify the type (e.g. adult briefs or under pads).
- If none of the above is clearly indicated, the case will be pended for a new prescription.
- The order/prescription must be on the ordering/prescribing doctor's script and not on a document made by the DME supplier.
  - CMN's created by the DME supplier will be accepted, but order must accompany the CMN.
- KEPRO is required to have an unexpired Rx on file with each request.
  - That does not mean a new prescription is required with each request, but if an Rx from within the past year is not found in the system the nurse reviewers will request it.

Example of CMN

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Bureau for Medical Services
Certificate of Medical Necessity
Durable Medical Equipment/Medical Supplies

SECTION I

MEMBER DATA	SERVICING PROVIDER	CMN Status
Medicaid ID#_____	Provider ID#_____	
Name_____	Provider Name_____	____Initial
D.O.B._____	Contact Person_____	____Revised
Phone # (___) _____	Phone # (____) _____	____Renewed

Section II MEMBER INFORMATION

Answer all questions that are applicable to DME/ Medical Supplies services being requested. If answer is Yes, You must describe/ attach additional information to support medical justification.

DOES PATIENT:	YES	NO
1. Have impaired mobility?	___	___
2. Have impaired endurance?	___	___
3. Have restricted activity?	___	___
4. Have skin break down? (Attach description of site, size, depth, and drainage)	___	___
5. Have impaired respiration? (Results of recent PO2/ saturation levels must be on file)	___	___
6. Require assistance with ADL'S ?	___	___
7. Have impaired speech?	___	___
8. Is item suitable for use in home and does the member/caregiver demonstrate willingness and ability to use the equipment?	___	___

9. Height: _____ Weight: _____

DATE PATIENT LAST EXAMINED BY PRACTITIONER: ____/_____/_____

ICD 9- CODES	CLINICAL DIAGNOSIS	DATE OF ONSET

SECTION III

Begin Service Date	HCPCS Code	Item Description	Estimated Length of Need (# Months)	Quantity and Frequency Of Use	Dollar Amount

SECTION IV PRACTITIONER CERTIFICATION OF MEDICAL NECESSITY

I certify that this patient meets the program eligibility criteria and that this equipment is a part of my course of treatment and is "Reasonable, Medically Necessary, and is most cost effective", and is not a convenience item for the member, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate. (Must be completed, signed and dated by the Practitioner.)

Prescribing Practitioner's Name	Practitioner's Signature	Date	ID #	Phone #

WVDHHR/BMS/CMU/CMN/Revised 04/2005

Non-Covered Incontinence Supplies

WV Medicaid Provider Manual Section 506.1.2

Covered medical supplies are based on product category, not specific item, brand, or manufacturer. Medical supplies are purchased items unlike equipment which may be initially purchased or reimbursed on a cap rental basis. Dispensing of medical supplies for more than a one month timeframe or shipping supplies on an unsolicited or automatic basis is prohibited.

- Incontinence items such as pads, panty liners, and related items are considered non-covered under HCPCS code A4520.
- Per Section 506.1.2, covered services are based on product category not specific item, brand, or manufacturer.
  - The name brand is not an issue for incontinence garments (e.g. Depends, etc.) as long as it is a diaper or brief garment that provides full coverage for incontinence.

New Code

As of May 1, 2017, T4535 has been added to our system per BMS. T4535 is described in the HCPCS manual as Disposable liner/shield/guard/pad undergarment for incontinence.

- This will be available for members three (3) years old and older
- With a service limitation of 180 per month
- There is a combination maximum of 250 per month for A4520, A4554, and T4535.
  - For example: T4535 – 180 liners; A4554 – 50 underpads; A4520 – 20 diapers equals 250 total combination.

NO AUTHORIZATION WILL BE GIVEN OVER THE MONTHLY AMOUNT ALLOWED.

Diagnosis

Medical necessity must be proven for the incontinence supplies.

Additional clinical information may be requested due to a medical diagnosis that does not confirm incontinence:

- Specifically the disease, condition or other factors that are resulting in incontinence (urinary or fecal).
- If the diagnosis that is provided with the request states it is drug induced urinary incontinence, the name of the drug must be indicated.
  - The research or side effects of that medication must be clear to cause incontinence.
- If clinical information is requested and not received, the case will be closed just as in the normal work flow, and must be resubmitted with the requested information to be reviewed.

Shower Chairs

Items being requested must be the most efficient and cost effective to meet the member's needs. Local medical policy states there is a cap on the total price of shower chairs.

- Shower chairs cannot exceed the total amount of $1,000.00.
  - The total amount *includes* the 40% markup given to providers.
    - Please note, this is a hard cap and cannot be exceeded by the prior authorization process.
- If shower chair exceeds the $1,000.00 price cap, the case will be denied per policy and a policy denial letter generated.

Oxygen and Oxygen Supplies

When submitting an initial prior authorization request for oxygen and oxygen supplies:

- A pulse ox and/or arterial blood gas (ABG) from the last 30 days must be included in the medical documentation.
- Any testing older than the 30 day span will not be accepted for the initial review.
- If the request is for a recertification, documentation with a pulse ox and/or ABG within 6 months can be accepted.

Is a prescription required for other DME supplies?

WV Medicaid Provider Manual Section 506.1

The Physician's prescription/order for other DME supplies must be available as part of the supporting documentation for the CMN and must be provided to the DME vendor and correspond to the CMN.

- The prescription/order is required along with the CMN and any other supporting documentation when prior authorization of incontinence supplies is requested.
- CMN and prescription are required for DME equipment such as wheelchairs and other mobility aids. The DME provider must provide additional assessment for these items.
- Verbal and E-Orders can still be provided. However, they must clearly indicate they are from the prescribing practitioner to the DME provider.
- While there is variance in formats of verbal and e-prescriptions, the ORP practitioner must be clear, the item(s) or service(s) needed must be clear, and the quantity and frequency must be clear. These are the core elements of the CMN and must correspond.

Is a prescription required for other DME supplies?

To view the WV Medicaid Provider Manual, please go to:

http://www.dhhr.wv.gov/bms/Pages/Manuals.aspx

DMEPOS is located in Chapter 506

KEPRO Contact Information

1-800-346-8272 MEDICAL SERVICES GENERAL VOICEMAIL- EXT. 7996 MEDICAL SERVICES EMAIL: WVMEDICALSERVICES@KEPRO.COM			
HELEN SNYDER	DIRECTOR	HCSNYDER@KEPRO.COM	EXT. 4463
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JAMI PLANTIN	ELIGIBILITY SPECIALIST	JAMI.PLANTIN@KEPRO.COM	EXT. 4502
ROMEDA HICKS	ELIGIBILITY SPECIALIST	RHICKS@KEPRO.COM	EXT. 4492

GENERAL KEPRO INFORMATION: WWW.WVASO.KEPRO.COM

FAX #: 866-209-9632 (REGISTRATION AND TECHNICAL SUPPORT ONLY)

WEBSITE FOR SUBMITTING AUTHORIZATIONS: HTTPS://PROVIDERPORTAL.KEPRO.COM

WEBSITE FOR ORG MANAGERS TO ADD/MODIFY USERS: HTTPS://C3WV.KEPRO.COM

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Questions?