North Carolina

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Attention:
Durable Medical Equipment Providers

Manual Pricing Calculation for Durable Medical Equipment Prior Approval Requests

DME Claims Submission Invoice Requirements for DME Providers

Modifications to Clinical Coverage Policy 5A

- **5.3.9 Oxygen, Oxygen Supplies, and Equipment**
- **5.3.11 Respiratory Devices for the Treatment of Respiratory Disorders other than Obstructive Sleep Apnea (OSA)**
- **5.6.2 Utilizing Delivery or Shipping Service**

Manual Pricing Calculation for Durable Medical Equipment Prior Approval Requests

Manual pricing calculation for Durable Medical Equipment (DME) Prior Approval requests approved according to the appropriate clinical policy procedures are:

- Providers must submit an invoice or quote (or an estimate if the request is for non-warranty repair) with DMA 372-131 form (Certificate of Medical Necessity/Prior Approval or CMN/PA) when requesting prior approval for a manually priced item.

- The maximum allowable rate will be the vendor's invoice or quote amount, **net** of all discounts, **plus** 20 percent. When freight is allowed, it will be added to the reimbursement at actual cost. If there are multiple items on the same invoice, the freight component of the maximum allowable rate will be the total freight charge divided by the number of items billed on the invoice.

There are several exceptions:

- **Wheelchairs and wheelchair accessories** are the **only** medical equipment supplies where the maximum allowable rate may be based on MSRP for prior approval purposes.
- **External insulin pumps** are covered in a separate pricing policy.
- **For procedure code A9999 - Farrell valves**, the designated maximum allowable rate is $8.48, until a memo is submitted changing the designated rate.

All other DME policies, such as paying lower of billed versus maximum allowable rate still apply. Provider should bill their usual and customary charge.

With the exception of wheelchairs, wheelchair accessories and Farrell valves, claims submitted for services which were authorized prior to Nov. 6, 2015 must include an invoice.

DME Claims Submission Invoice Requirements for DME Providers

DME services indicating "manually priced" on the DMA fee schedule require an invoice for claims processing. The exception to this requirement is wheelchairs, wheelchair accessories, Farrell valves (A9999), and services which Medicare is primary payer. Follow the instructions below when submitting claims for manually priced services which are not an exception to the invoice requirement:

- Services authorized prior to November 6, 2015 must include an invoice with the claim submission regardless of documentation submitted with the PA request.
- Services authorized on or after November 6, 2015 should include the invoice with the claim submission only when the invoice was not originally submitted with the prior authorization request.
- Manually priced services that do not require PA should always include an invoice with the claim submission.

Invoices can be uploaded through the portal and attached to the claim.

Claims which previously denied for invoice requirements may be resubmitted for processing following the above guidelines.

5.3.9 Oxygen, Oxygen Supplies, and Equipment

Effective **April 25, 2016** Durable Medical Equipment (DME) providers requesting prior authorization for **Oxygen, Oxygen Supplies, and Equipment** as described in section **5.3.9** of **Clinical Coverage Policy 5A** should note the following changes to the prior authorization process:

Prior Approval Requirements

For initial approval on oxygen services, the following must be in block 25 of the CMN/PA form or on attached documentation:

a. Health record documentation from the beneficiary's prescriber stating why the use of oxygen is indicated.
b. Health record documentation from the beneficiary's prescriber showing that the beneficiary has had an examination within 30 calendar days of the start of oxygen therapy. The documentation must list ALL of the following:

    1. The diagnosis of the disease requiring use of home oxygen;
    2. The oxygen flow rate needed; and
    3. An estimate of the frequency, duration of use, and length of need for the oxygen.

c. Results of an oxygen analysis (either ABG or pulse oximetry for SaO2) as noted in the **Requirements for Qualifying Oxygen Analysis and Coverage**.

d. Initial prior approval is given for 12 calendar months for a beneficiary under age 21 years of age, or who qualifies for oxygen under Group I criteria.
e. Continuation prior approval for this beneficiary is required at the end of the 12 calendar months.
f. Initial prior approval is given for three (3) calendar months for a beneficiary who qualifies for oxygen therapy under Group II criteria. Continuation prior approval for this beneficiary is required at the end of the three (3) months. For a beneficiary initially meeting Group II criteria, the most recent blood gas study that was performed between the 61st and 90th day following initial Certification must be reported on the Recertification CMN/PA. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy, but the beneficiary continues to use oxygen and a test is obtained at a later date, if that test meets Group. I or II criteria, coverage would resume beginning with the date of that test. For a beneficiary initially meeting Group I or II criteria, the beneficiary must be seen and re-evaluated by the treating prescriber within 90 calendar days prior to the date of any Recertification. If the prescriber's visit is not obtained within the 90-day window, but the beneficiary continues to use oxygen, and the visit is obtained at a later date, coverage would resume beginning with the date of that visit.

g. Repeat testing is not required in cases where equipment is replaced. Enter the most recent qualifying value and test date. This test does not have to be within 30 calendar days prior to the Initial Date, but could be the test result reported on the most recent prior CMN/PA.
h. There is no requirement for a prescriber's visit that is specifically related to the completion of the CMN/PA for replacement equipment.
i. When the prescribed maximum flow rate changes from one of the following categories to another, a repeat blood gas study with the beneficiary on 4liters per minute (LPM) must be performed and this
j. Must be the most recent study obtained within 30 calendar days prior to the Initial Certification Date:
    1. Less than 1 LPM,
    2. 1- 4 LPM,
    3. Greater than 4 LPM
k. When the length of need expires – if the prescriber specified less than lifetime length of need on the most recent CMN/PA, then the blood gas study must be the most recent study obtained within 30 calendar days prior to the Initial Date.
l. When a portable system is added subsequent to Initial Certification of a stationary system, there is not a requirement for a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the beneficiary is at rest (awake) or during exercise within 30 calendar days prior to the Revised Date.

If the beneficiary meets the criteria, the second continuation prior approval is given for an additional 24 months.

At the end of 36 months, all beneficiaries shall be recertified. The provider shall submit a new prior approval request for the continuation of oxygen therapy. This request must include a qualifying oxygen analysis that was obtained and reviewed by the treating prescriber within six (6) months of the renewal date. Approval given at the 36-month renewal period is considered to be lifetime approval.

Note: Continuation prior approval for oxygen therapy is not required if oxygen therapy for use with a continuous positive airway pressure (CPAP) device or respiratory assist device (RAD) for obstructive sleep apnea (OSA) has been diagnosed and initially approved, or ventilator dependency for respiratory failure.

Special Reimbursement Explanation: Oxygen contents are approved only for beneficiary-owned equipment. This includes portable tanks, liquid oxygen, and oxygen tanks that are used on an ongoing basis, based on prior approval and medical necessity.

Coverage is described as follows:

a. For a beneficiary receiving oxygen therapy delivered by an oxygen concentrator and also prescribed a portable oxygen system, reimbursement is for rental on the oxygen concentrator and portable oxygen tank. There is no separate coverage for contents that are used by the portable system, regardless of the amount of portable oxygen contents used in that month, as rental for the oxygen systems include contents.
b. For a beneficiary who is on a stationary liquid oxygen system and portable liquid oxygen system, coverage is for rental at the published rate for both a stationary liquid oxygen system and a

portable system. Contents are covered in the published rate, and no additional contents are separately approved for a monthly rental.

c. Portable oxygen systems — A beneficiary who meets the clinical coverage criteria for medical necessity may qualify for coverage of a portable oxygen system either by itself or to use in addition to a stationary system. The qualifying health record documentation must indicate that the beneficiary is mobile in the home and would benefit from the use of the portable oxygen system in the home. Portable oxygen systems that are used on a standby basis are not covered except in instances of a fragile infant with a tracheostomy.
d. If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow of greater than 4 (LPM) will be paid only if a blood gas study performed while the beneficiary is on 4 LPM meets Group I or II criteria. If a flow rate greater than 4 LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance. The higher oxygen allowable will be paid to the supplier at 1.5 times the rate. A modifier must be added to the oxygen code being used. If a modifier is used, then only the 1.5 times the rate will be reimbursed and there will be no payment for the portable oxygen system. Refer to **Attachment A, Section D**, for a list of the modifiers that must be used.

A Carbon Dioxide **(CO2) Saturation Monitor with Accessories and Probes** is considered medically necessary when it is required to monitor carbon dioxide (CO2) levels in beneficiaries requiring oxygen therapy, so that appropriate blood gas levels are achieved and maintained.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, Oxygen Equipment and Supplies.

5.3.11 Respiratory Devices for the Treatment of Respiratory Disorders other than Obstructive Sleep Apnea (OSA)

Effective **April 25, 2016** Durable Medical Equipment (DME) providers requesting prior authorization for **Respiratory Devices for the Treatment of Respiratory Disorders other than Obstructive Sleep Apnea (OSA)** as described in section **5.3.11** of **Clinical Coverage Policy 5A** should note the opening paragraph under **Other Respiratory Devices** shall now read:

Other Respiratory Devices

A ventilator is covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Coverage is provided for both positive and negative pressure ventilators. Prior approval is required for a ventilator. Recertification is at 12 months. A lifetime PA may be considered at recertification if medical necessity is demonstrated.

For a list of the specific HCPCS codes covered, refer to **Attachment A, Section C: Codes** Lifetime Expectancies and Quantity Limitations for Durable Medical Equipment and Supplies, *Respiratory Devices – Other.*

5.6.2 Utilizing Delivery or Shipping Service

Effective **April 25, 2016** Durable Medical Equipment (DME) providers delivering DME and suppliers as described in section **5.6.2 Utilizing Delivery or Shipping Service** of **Clinical Coverage Policy 5A** should note the following change:

When a provider utilizes a shipping service or mail order, the provider shall report the shipping date as the date of service on the claim. Proof of delivery is required. The provider's records shall include the shipping service's package identification number for the package sent to the beneficiary. The shipping service's tracking slip must reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and the delivery date. In case of lost, stolen, damaged or incomplete delivery of specified medical equipment or supplies; it is the provider's responsibility to replace the specified medical equipment or supplies without cost to the beneficiary or Medicaid and NCHC. It is expected that the replacement occurs within 48 hours.

Additional Resources

For more information, please consult **Clinical Coverage Policy 5A,** *Durable Medical Equipment and Supplies***:**

- **Section 5.3.9 Oxygen, Oxygen Supplies, and Equipment**
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- **Section 5.6.2 Utilizing Delivery or Shipping Service**

DMA Clinical Policy and Programs
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