ForwardHealth
Wisconsin serving you

Update
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Affected Programs: BadgerCare Plus, Medicaid
To: Federally Qualified Health Centers, Home Health Agencies, Individual Medical Supply Providers, Medical Equipment Vendors, Nursing Homes, Occupational Therapists, Physical Therapists, Pharmacies, Rehabilitation Agencies, Therapy Groups, HMOs and Other Managed Care Programs

Procedure Code Updates for Durable Medical Equipment

ForwardHealth is updating durable medical equipment coverage, policies, and limitations.

ForwardHealth is updating durable medical equipment (DME) coverage, policies, and limitations. Some of the changes are due to 2009 and 2010 Healthcare Common Procedure Coding System (HCPCS) procedure code changes. Other changes are to streamline business and reduce paperwork for providers. These changes include the following:

- Adding new HCPCS procedure codes.
- Discontinuing certain HCPCS procedure codes.
- Changing the prior authorization (PA) requirement for certain HCPCS procedure codes.
- Decreasing the life expectancy of certain DME.

Refer to the DME service area of the Online Handbook on the ForwardHealth Portal for all DME policies and procedures.

Changes to Reimbursement and Quantity Limits of Procedure Codes

Providers are reminded that the interactive maximum allowable fee schedule is updated periodically. ForwardHealth will no longer issue *ForwardHealth Updates* when the maximum allowable fees for DME change. Providers should monitor the interactive fee schedules on the ForwardHealth Portal at *www.forwardhealth.wi.gov/* at least every six months for the most up-to-date pricing.

Providers should use the interactive fee schedule for other policies and reimbursement information of DME items. Providers may also use the extract file version of the downloadable DME Index, available on the Fee Schedule page of the Portal, for reimbursement information of DME items. Providers should only refer to the Portable Document Format (PDF) version of the downloadable DME Index, for information about PA policy for DME. The PDF version should not be consulted for any other policy information.

Adding Maximum Allowable Fees

In order to help maintain consistent pricing, ForwardHealth has determined maximum allowable fees for certain HCPCS procedure codes that were previously manually priced. Refer to Attachment 2 of this *Update* for a complete list of DME procedure codes that are no longer manually priced.

New HCPCS Procedure Codes

The following procedure codes are reimbursable effective for dates of service (DOS) on and after January 1, 2009:

- A6545, A9284.
- E0487, E0656-E0657, E0770, E2230-E2231, E2295.

- K0606-RR, K0672.
- L0113, L6703, L6711-L6714, L6721-L6722.

The following procedure codes are reimbursable effective for DOS on and after January 1, 2010:

- A6549 (replaces A6542).
- K0739 (replaces E1340.)
- L2861, L8031-L8032, L8627–L8629.

Providers may now submit claims to ForwardHealth for any of the new HCPCS procedure codes. Payments made by members for the services must be refunded to the members after reimbursement is received from ForwardHealth.

For DOS more than 365 days in the past, providers have until July 1, 2010, to submit claims to Timely Filing. A separate Timely Filing Appeals Request form, F-13047 (10/08), must be submitted with each claim, and in the space provided at the bottom of the form (immediately above the signature), providers should enter: "New HCPCS code for DME."

Note: The following procedure codes are new as of January 1, 2010, but are not covered under ForwardHealth.

- E0433.
- K0740.

Discontinued HCPCS Procedure Code

The following procedure codes have been discontinued and are no longer reimbursable on and after January 1, 2009:

- L2860, L3890, L5995.
- L7611-L7614, L7621-L7622.

The following procedure codes have been discontinued and are no longer reimbursable on and after January 1, 2010:

- A6542 (replace with A6549).
- E1340 (replace with K0739).
- E2393.
- E2399.
- L0210, L1800, L1815, L1825, L1901, L2770, L3651-L3652, L3700-L3701, L3909-L3911, L6639.

Providers are reminded to use the procedure code on claims and PA requests that best describes the item dispensed or to be dispensed. Providers are also reminded that it is the provider's responsibility to amend any currently approved or modified PAs for discontinued procedure codes for DOS on and after January 1, 2010. Discontinued procedure codes are not reimbursable, even if they were prior authorized.

Modifier "RP" for Miscellaneous Repair Is Replaced by Modifier "RB"

Effective for DOS on and after January 1, 2009, providers should use modifier "RB" (Replacement of a part of DME furnished as part of a repair) when submitting claims for miscellaneous repair parts for most wheelchair, hospital bed, patient lift, and commode chair procedure codes. Modifier "RP" has been discontinued as of December 31, 2008.

The "RB" modifier may be used with all DME procedure codes where the "RP" modifier was used. Effective for DOS on and after January 1, 2009, the "RB" modifier may be used with procedure codes for powered mobility equipment. Refer to Attachment 1 for a complete list of powered mobility equipment procedure codes that may now be used with the "RB" modifier. Refer to the DME service area of the Online Handbook on the Portal for all DME policies and procedures.

Providers are reminded not to use the "RB" modifier with a procedure code if there is a specific procedure code for the requested part (e.g., procedure code E0952 [Toe loop/holder, any type, each]).

Claims Submitted with the "RB" Modifier

Claims submitted with the "RB" modifier in the first year following the purchase DOS of the equipment will be denied. Providers are reminded to submit their usual and customary charges on claims with details that contain the "RB" modifier.

Prior Authorization for the "RB" Modifier

Repairs for DME do not require PA if *all* of the following are true:

- The charge is for repair parts for equipment that have been identified for use with the "RP" or "RB" modifier and is either of the following:
  - ✓ $50 or less for all DME except powered mobility equipment.
  - ✓ $100 or less for powered mobility equipment. (The powered mobility equipment limit has increased from $50 to $100 as of January 1, 2009.)
- The DME is more than one year old.
- Wisconsin Medicaid and BadgerCare Plus purchased the equipment.

When PA is required, providers should not indicate the "RB" modifier on PA requests or amendments.

Documentation Requirements Reminder

Provider records must support all services billed for a claim. Providers should retain all documentation for claims. Providers are reminded that they are required to prepare and maintain truthful, accurate, complete, legible, and concise documentation of the member's continuing use of the equipment, as well as documentation of all DME services as stated in DHS 106.02(9)(a), Wis. Admin. Code.

Changes to Prior Authorization Requirements

Effective immediately, PA is no longer required for the following procedure codes:

- E0271-E0272, E0305-E0310, E0959-E0960, E0974, E1020, E2602-E2607.
- K0015-K0020, K0065.
- L8015.

Effective immediately, PA is required for procedure codes L3900-L3904.

Refer to Attachment 2 for a complete list of changes made regarding PA requirements.

Prior Authorization Is Changed for Wheelchair Repair

Effective immediately, the PA limit for wheelchair repair is changed. Prior authorization is required when one of the following is true:

- Procedure code K0739 is requested for greater than eight units.
- The procedure code needed for the repair requires PA.
- The repair is in excess of the limit that would allow the provider to bill using only the "RB" modifier.

Changes to Equipment Life Expectancy

Effective immediately, life expectancy for the following procedure codes has changed as described:

- E0960 is decreased to one year.
- E0978 is decreased to two years.
- E2619 is decreased to two years.

Refer to Attachment 2 for a complete list of changes made to equipment life expectancy.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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ATTACHMENT 1
Procedure Codes for Powered Mobility Equipment That May Be Used with the "RB" Modifier

Effective for dates of service on and after January 1, 2009, for powered mobility equipment repairs, the following table lists all of the procedure codes for powered mobility equipment that may now be used on claims with the "RB" modifier. This list applies to Wisconsin Medicaid, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan.

Procedure Codes			
E1230	K0821	K0842	K0864
E1230-59	K0822	K0843	K0868
K0010	K0823	K0848	K0869
K0011	K0824	K0849	K0870
K0012	K0825	K0850	K0871
K0014	K0826	K0851	K0877
K0800	K0827	K0852	K0878
K0801	K0828	K0853	K0879
K0802	K0829	K0854	K0880
K0806	K0830	K0855	K0884
K0807	K0831	K0856	K0885
K0808	K0835	K0857	K0886
K0812	K0836	K0858	K0890
K0813	K0837	K0859	K0891
K0814	K0838	K0860	K0899
K0815	K0839	K0861	
K0816	K0840	K0862	
K0820	K0841	K0863	

ATTACHMENT 2
Durable Medical Equipment Procedure Code Changes: January 2010

The following table summarizes the recent changes made to certain Healthcare Common Procedure Coding System procedure codes. These code changes apply to Wisconsin Medicaid, the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and the BadgerCare Plus Core Plan for Childless Adults. Providers should refer to the maximum allowable fee schedule for pricing.

Procedure Code	Changes to Prior Authorization Requirements	Changed from Manually Priced to Maximum Allowable Fee	Changes to Equipment Life Expectancy
E0271	PA no longer required		
E0272	PA no longer required		
E0305	PA no longer required		
E0310	PA no longer required		
E0959	PA no longer required		
E0960	PA no longer required		Decreased to one year
E0974	PA no longer required		
E0978			Decreased to two years
E1003		X	
E1004		X	
E1020	PA no longer required		
E2368		X	
E2369		X	
E2370		X	
E2381		X	
E2382		X	
E2383		X	
E2384		X	
E2385		X	
E2386		X	
E2387		X	
E2388		X	
E2389		X	
E2390		X	
E2391		X	
E2392		X	
E2394		X	
E2602	PA no longer required		

Procedure Code	Changes to Prior Authorization Requirements	Changed from Manually Priced to Maximum Allowable Fee	Changes to Equipment Life Expectancy
E2603	PA no longer required		
E2604	PA no longer required		
E2605	PA no longer required		
E2606	PA no longer required		
E2607	PA no longer required		
E2619			Decreased to two years
K0015	PA no longer required		
K0017	PA no longer required		
K0018	PA no longer required		
K0020	PA no longer required		
K0065	PA no longer required		
L3806		X	
L3808		X	
L3900	PA now required		
L3901	PA now required		
L3904	PA now required		
L3905		X	
L3967		X	
L6703		X	
L6706		X	
L6707		X	
L6708		X	
L6709		X	
L8015	PA no longer required		