WISCONSIN MEDICAID

UPDATE

JULY 1, 1998

UPDATE 98-21

TO:
DME Vendors
Home Health Agencies
HMOs and Other Managed Care Programs
Nursing Homes
Occupational Therapists
Orthotists
Pharmacies
Physical Therapists
Prosthetists
Rehabilitation Agencies
Speech and Language Pathologists
Therapy Groups

DME Prior Authorization, Coding, and Repairs

Clarification and new policies for DME

This Update clarifies Wisconsin Medicaid's policies on prior authorization (PA) and the use of procedure codes, describes plans to streamline PA and remove PA requirements for certain items, and presents new repair policies. The intent of the Update is to improve the PA process and repair policies and to increase provider understanding of Medicaid policies.

Prior authorization (PA)

Removal of PA requirements

Effective for services provided on and after August 1, 1998, PA is not required for:

- E0163—commode chair, stationary, with fixed arms.
- E0607—home blood glucose monitor.
- E0570—nebulizer: with compressor, e.g., Devilbiss Pulmo-aid.

For home blood glucose monitors, providers must obtain and maintain on file doctor's orders that document insulin dependency of the individual. PA is still required for E0609, blood glucose monitor with special features (e.g., voice synthesizers, automatic timers, etc.).

PA requests from two providers for the same equipment for a recipient

Wisconsin Medicaid will not approve a second PA request when a PA for the same equipment has already been approved for a recipient from another provider. Since the second requestor has no way of knowing whether the equipment has been provided, Wisconsin Medicaid, upon request, will identify the original provider.

Plans to expedite the PA process

Wisconsin Medicaid is developing procedures to allow the exchange of information between providers and the Medicaid fiscal agent by telephone and fax. A future Update will outline when telephone and fax may be utilized. Please do not use telephone or fax until an Update is published.

Coding

Changes to augmentative communication devices

Effective February 23, 1998, Wisconsin Medicaid removed the reimbursement limitation for procedure code W6808 "Communicator, including accessories and repairs," type of service (TOS) purchase (P), and TOS rental (R). Wisconsin Medicaid will adjust claims processed and paid on and after February 23, 1998, to reflect this change.

In addition, Wisconsin Medicaid will review PAs processed on and after February 23, 1998, to amend PAs that inappropriately denied or modified medically necessary communicators and accessories. Providers will be notified when claims are adjusted and when PAs are amended via remittance and status reports and other messages.

Effective February 23, 1998, Wisconsin Medicaid also changed the procedure code description for procedure code W6808, TOS P and TOS R. The new description for procedure code W6808 is "Communicator, including accessories." Also effective February 23, 1998, the ten-year lifetime limit for reimbursement of a new communicator is removed.

The procedure continues to require PA for reimbursement by Wisconsin Medicaid. The PA request should separately itemize all accessories for Medicaid reimbursement.

Repairs and modifications to augmentative communication systems/ devices

Repairs and modifications to augmentative communication systems/devices are now covered under procedure code V5336.

Effective for dates of service on and after February 23, 1998, use procedure code V5336, "Repair/modification of augmentative communication system or device (excludes adaptive hearing aid)," TOS P, to request reimbursement for repairs and modifications to augmentative communication devices. This includes both labor and parts.

The new code requires PA for repairs and modifications exceeding $150.00. Wisconsin Medicaid does not provide additional reimbursement for travel for repairs of an augmentative communication device. Repairs will be separately reimbursed for nursing home recipients.

Deletion of local code for nebulizer

In reviewing codes for nebulizers, Wisconsin Medicaid determined that W6791, nebulizer—durable hand-held, small reservoir—duplicates other codes. W6791 will be deleted and may not be used for dates of service on and after August 1, 1998.

Clarification on coding and unlisted DME items

If a DME item is prescribed that does not have a specific procedure code in the DME Index, Wisconsin Medicaid requires the provider to request PA for the item using the appropriate "not otherwise classified" (NOC) procedure code in the DME Index. Use NOC codes *only when no other code or combination of codes* describes the item.

Wisconsin Medicaid establishes maximum allowable fees with all commonly requested sizes and variations taken into consideration. In rare cases, when the medical necessity is established for an extraordinary size or variation of an item that is described by a specific code and for which there is a significant additional charge by the manufacturer, an NOC code may be used to request this item. Wisconsin Medicaid will consider approval based on the information providers submit. Information must include the manufacturer's list price with a specific description of the product.

In certain circumstances, Wisconsin Medicaid may determine that the item requested contains features not required by the recipient's condition. If there is a reasonably feasible and medically appropriate alternative item which is less costly, Wisconsin Medicaid may approve a different code for the item rather than deny the item. If the provider believes the assigned code is

inappropriate, an amendment may be submitted, with supporting documentation justifying the requested code change.

Repairs

Repair policies effective August 1, 1998

Effective for dates of service on and after August 1, 1998, the following repair policies apply to all DME repairs.

Continue to use current codes L4210 and L7510 for repair of orthotics and prosthetics. New codes, E1340 and W6804, are used for labor and repair of equipment.

E1350, repair or non-routine service, will be deleted and may not be used for dates of service on and after August 1, 1998.

Wisconsin Medicaid will not reimburse for excessive repairs when purchase of a new item would be more cost effective. Likewise, Wisconsin Medicaid will not approve purchase of a new item when only simple repairs are needed.

As part of the PA process, Wisconsin Medicaid determines if it is more cost-effective to purchase an item than to repair it, and to determine if the requested modifications are medically necessary.

The PA request must include an estimate of the cost for the entire service, an itemized list of needed parts, and the approximate cost of each part.

When requesting PA for a repair, Wisconsin Medicaid requires providers to include documentation of what is being done to repair the item (e.g., repair of joy stick), the reason for the repair, and charges listed separately for parts and labor. A copy of the work order may be attached to the PA request if it provides this information.

Labor—Use E1340 to bill for labor (actual time spent repairing equipment), with an all-inclusive maximum allowable fee of $10.50 per 15 minutes. In other words, if 15 minutes are spent repairing equipment, providers must indicate a unit of one in the unit field on the claim form. Two units in the unit field equal 30 minutes. A decimal point may be used to indicate when a fraction of a whole unit is billed. Bill your usual and customary hourly rate. Time billed is subject to PA and post-pay review, using industry standards for repair time.

Parts used in repairs

Use a specific code if a specific code describing a part is available. Use W6804 (a new Medicaid local code) for miscellaneous parts and incidentals required for the repair for which there are no specific codes and that are not included as part of a specific code. W6804 may only be used for repairs, not upon initial issue of equipment. Wisconsin Medicaid requires providers to bill W6804 on the same date of service as E1340, or W6804 will be denied.

Part replacement

Wisconsin Medicaid makes no distinction between repair and part replacement. Providers may bill for the time spent replacing a worn or broken part.

Travel

Wisconsin Medicaid does not provide additional reimbursement for travel. Thus, providers may not bill travel as part of labor time. Bill only for time actually spent repairing equipment. Reimbursement for E1340 is all-inclusive of overhead, travel, delivery, etc.

PA for repairs

Wisconsin Medicaid requires PA in the following situations:

- When a total repair exceeds $150 (combination of labor and parts, including both miscellaneous parts billed with W6804 and parts with specific codes).
- When labor alone is estimated to exceed $84 (two hours).

- When miscellaneous parts and incidentals are billed under the new local code W6804 and are expected to exceed $50.

- When parts requiring PA, as listed in the DME Index, are used in a repair.

- When replacing a part before the end of its life expectancy *(this always requires PA)*.

Always bill repairs per *complete* service, not per date of service. Wisconsin Medicaid requires that providers estimate the cost of providing the complete service before initiating the service. If you are unsure whether the total cost of providing the service exceeds the PA threshold, submit a PA request as a precautionary measure to avoid claim denial.