

HealthSystems



HealthSystems
OF MISSISSIPPI

A blue silhouette of the state of Mississippi is positioned behind the title text.

Durable Medical Equipment Provider Manual

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Of Mississippi

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I. Introduction

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform certification and quality of care review for durable medical equipment, orthotics, prosthetics and certain medical supply services provided to Mississippi Medicaid beneficiaries.

Our review is performed for the following types of services:

- Inpatient Acute Hospitals.
- Free Standing Psychiatric Inpatient Hospitals.
- Psychiatric Residential Treatment Facilities.
- MYPAC – Mississippi Youth Programs Around the Clock.
- Hospital Outpatient Mental Health Services.
- Community Mental Health Post Payment Review.
- Outpatient Physical, Occupational and Speech Therapy.
- School Health Related Outpatient Physical, Occupational and Speech Therapy.
- Home Health.
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies.
- Private Duty Nursing.
- Medical Necessity Review for Organ Transplant.

The purpose of this manual is to assist providers in successfully navigating through HSM's review requirements and process.

II. Getting Started - Helpful Tips

Before submitting any request to HSM, providers must verify beneficiary eligibility and available benefits through DOM's fiscal agent at: <https://msmedicaid.acs-inc.com/msenvision/index.do> or 1-800-884-3222 or 601-206-3000. The above contact information is also used if you have a billing question.

Providers must read and be familiar with DOM's policies and procedures located at: <http://www.medicaid.ms.gov/manual.aspx>.

The Division of Medicaid requires that DME, orthotics, prosthetics and/or certain supplies (diapers and underpads) are certified by HSM.

III. Information You Need to Know

DME requests are accepted by fax or mail. Required forms must be downloaded from DOM Provider Policy Manual at <http://www.medicaid.ms.gov/manual.aspx>.

A dedicated DME fax number is provided to assist with certification needs. Although we can accept mailed requests, fax submission provides the most expedient response to your request. The table below lists fax and phone numbers, and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
DME Certification Review Request Submission	Used by providers to submit review requests and additional information requested by HSM.	Hours: 24 hours, 7-days a week. Review information received after 5:00 p.m. or over the weekend or holidays are considered received the next business day. Fax: 1-888-204-0159 Mail: 175 East Capitol Street Suite 250, Lockbox 13 Jackson, MS, 39201
Helpline	Used by providers for questions regarding the certification process and to request assistance.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Local: 601-360-4949 Toll Free: 1-866-740-2221
Hot Line	Used by beneficiaries and providers to report quality concerns and/or complaints.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Toll Free: 1-888-204-0221

Electronic Helpline Inquiries

Providers are encouraged to use HSM's HIPAA secure Web-based system to electronically submit helpline inquiries. One of the benefits to providers who are enrolled to use the electronic Web system is that you can check the status of your reviews at any time. The reporting module is provider-specific and available 24 hours a day 7 days a week.

If you do not have a HSM logon, contact HSM's Education Department at education@hsom.org or by phone at (601)-360-4949 or toll-free at 1-866-740-2221 to request enrollment and training.

In addition to Internet access, minimum computer specifications are:

- Pentium 133 with 32 RAM and 8 mg free space for drivers.
- Color monitor.
- 28.8K modem connection or higher (phone line quality will determine speed of connection).
- Internet Explorer Version 4.0 or higher.

K-baby Admissions

Providers may access a list of K-Baby reviews that have been performed on our Web system. We also notify each DME provider of K-Baby reviews via a weekly faxed list. In order for HSM to release the treatment authorization number (TAN) the DME provider should:

- Obtain the baby's personal Medicaid ID number and date of birth. Access our Web system reports module and enter the required information, or
- Record the baby's personal Medicaid ID number and date of birth in the space provided on the faxed list and fax the updated list to us.

This information will be used to update the review certified under the mother's Medicaid ID number to the baby's Medicaid ID number. Only after this process has occurred can the previously issued TAN be transmitted to the Fiscal Agent (FA). Claims for services should not be submitted to the FA until after this activity has been performed.

IV. DME, Orthotics, Prosthetics and Supplies Review Exclusions

Medicaid policy exempts certain services from HSM certification and the provider should not submit review requests for these situations. HSM will not process requests that meet these policy conditions. The following are reasons for review exclusion.

Reason	Description
Medical Supply – HSM certification not required.	Medical supplies, <u>except diapers and underpads</u> , are exempt from HSM certification. Please refer to DOM's DME Medical Review Policy (criteria) on DOM's website (http://www.medicaid.ms.gov/manual.aspx) for a complete listing of items which do not require certification by HSM.
Items furnished by home health or physician.	HSM cannot perform review for items furnished by a home health agency or a physician.
No Medicaid Eligibility	No HSM review is required if the beneficiary does not have current Medicaid eligibility. If the patient has applied for Medicaid and the <u>eligibility determination is pending</u> , HSM cannot perform review. Once eligibility has been determined, HSM performs review based on the eligibility begin date.
Medicare Eligibility	No HSM review is required if the beneficiary has Medicare coverage (Part A or Part B), except when the request is for bath benches or diapers.
Long Term Care	No HSM review is required if the beneficiary is in a long-term care and/or ICF/MR facility. Oxygen cylinders and ventilators are reviewable if: <ol style="list-style-type: none"> 1. The item is not covered by Medicare. 2. The nursing facility does not include the cost of the item(s) in their annual cost report.
Hospice	No HSM review is required if the beneficiary is in a hospice program.
SNF Resident	No HSM review is required if the beneficiary is in a skilled nursing facility (SNF).

V. Certification Review Process

A. Requests for Certification Review

Providers submit requests for review directly to HSM. DME requests are accepted by fax or mail. Required forms must be downloaded from DOM Provider Policy Manual at <http://www.medicaid.ms.gov/manual.aspx>.

Review request and supporting documentation must be submitted within the specified timeframes. The following table describes the types of review, timeframes for submission, and required documentation for each type of review.

Review Type	Timeframe	Required Documentation												
Admission	Prior to or within 30 days of delivery.	<ul style="list-style-type: none"> Completed HSM Plan of Care (POC) form. The appropriate Certificate of Medical Necessity (CMN) form. Physician's Order (May be on the CMN or separate). <p>Additional documentation or specific modifiers are required as displayed in the following table.</p>												
Retrospective Review	Within one year of a retroactive Medicaid eligibility determination.	<table border="1"> <thead> <tr> <th>If the requested item is ...</th> <th>Then also submit the...</th> </tr> </thead> <tbody> <tr> <td>E1220 – Custom Wheelchair</td> <td>Seating Evaluation</td> </tr> <tr> <td>E0601 – (CPAP) and the modifier is NU.</td> <td>Physician Certifying Statement</td> </tr> <tr> <td>E0470 – (BiPAP) and the modifier is NU.</td> <td>Physician Certifying Statement</td> </tr> <tr> <td>Manually Price</td> <td>See “<i>Manually Priced Items</i>” below.</td> </tr> <tr> <td>Rented Items</td> <td>See “<i>Rental Request</i>” below.</td> </tr> </tbody> </table>	If the requested item is ...	Then also submit the...	E1220 – Custom Wheelchair	Seating Evaluation	E0601 – (CPAP) and the modifier is NU.	Physician Certifying Statement	E0470 – (BiPAP) and the modifier is NU.	Physician Certifying Statement	Manually Price	See “ <i>Manually Priced Items</i> ” below.	Rented Items	See “ <i>Rental Request</i> ” below.
		If the requested item is ...	Then also submit the...											
		E1220 – Custom Wheelchair	Seating Evaluation											
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		Manually Price	See “ <i>Manually Priced Items</i> ” below.											
Rented Items	See “ <i>Rental Request</i> ” below.													
Required forms are found in the DOM Provider Policy Manual at http://www.medicaid.ms.gov/manual.aspx .														

Manually Priced Items

When requesting manually priced items, the DME provider must indicate the name of the product, the product number, and the name of the manufacturer or distributor and must provide the required documentation for pricing. Providers are entirely responsible for submitting the correct documentation and requesting appropriate manual pricing. Providers should be able to produce documentation to show the charges can be substantiated if audited.

- The provider must submit clear written, dated documentation from a manufacturer or distributor that specifically states the MSRP for the item. This documentation may be provided with an official manufacturer's or distributor's letterhead, price list, catalog page, or other forms that clearly show the MSRP. The documentation may be sent to HSM via regular mail or fax. It is the responsibility of the provider to clearly note the MSRP on the documentation. If the MSRP is not clearly documented, the request may be denied.
- A manufacturer or distributor quote may be substituted for an MSRP if the manufacturer does not make an MSRP available. The quote must be in writing from the manufacturer or distributor and must be dated.
- Items that do not have a fee or MSRP may be priced at the provider's cost plus 20%. The provider must attach a copy of a current invoice indicating the cost to the provider for the item dispensed and a statement that there is no MSRP available for the item. If the provider purchases from the manufacturer, a manufacturer's invoice must be provided. If the provider purchases from a distributor (not directly from the manufacturer), the invoice from the distributor must be provided. Quotes, price lists, catalog pages, computer printouts, or any form of documentation other than an invoice are not acceptable for this pricing solution. The invoice must not be older than one year prior to the date of the request; exceptions to the one-year requirement may be approved only for unusual circumstances.

These procedures apply regardless of whether the DME provider is also the manufacturer, or the provider is purchasing from a manufacturer or from a distributor/supplier. Refer to DOM's DME Provider Policy Manual Section 10.02 at <http://www.medicaid.ms.gov/manual.aspx> for additional details.

Rental Requests

The following table displays instructions regarding the use of specific modifiers for requests involving rental items.

If the rental type is	Then the provider	And, if applicable
Monthly basis	Assigns a modifier or "RR" to the HCPCS code. Note: Equipment rental may be rented for up to ten months, with the exception of oxygen and oxygen related equipment.	HSM notifies the provider if the equipment has been rented for the allowable ten months and that the equipment is considered purchased and is the property of the beneficiary.
Daily or partial month basis	Assigns a modifier of "KR" to the HCPCS code.	

B. Processing of Review Requests

HSM has a diverse group of professionals that assist at various stages of the review process such as our Intake staff, who handle administrative functions. Our clinical staff is composed of registered nurses, physicians and physician consultants. These highly qualified professionals make certification review determinations for hospital durable medical equipment, orthotics, prosthetics and medical supplies. The following table describes our staff's functions.

Staff	Functions
Non-clinical Support Staff (Intake Staff)	<ul style="list-style-type: none"> • Screen requests for completeness. May request additional non-clinical information. • Perform verbal notification of review determination, as appropriate. • Support all review functions.
First level reviewers (Registered Nurses)	<ul style="list-style-type: none"> • Apply DOM policy. • Apply DOM approved medical necessity criteria. • May request additional information. • Approve services based on DOM policy or criteria. • Manually price items as necessary. • Refer requests that cannot be approved to a physician.
Second level Reviewers (Physicians)	<ul style="list-style-type: none"> • Make certification, denial or reconsideration determinations. The determination is: <ul style="list-style-type: none"> - Based on documentation that supports medical necessity and appropriateness of setting. * - Patient-centered and takes into consideration the unique factors associated with each patient care episode. - Sensitive to the local healthcare delivery system infrastructure. - Based on his or her clinical experience, judgment and generally accepted standards of healthcare. • May request additional information. <p>*The physician reviewer may request additional information and attempts to contact the ordering specialty (physician/physician assistant/nurse practitioner) to obtain additional information when the documentation submitted does not clearly support medical necessity.</p> <p>Note: See the Reconsideration Process section of this manual for information on the reconsideration process.</p>

There are three types of situations that may cause a review to be pended for additional information. The following table describes each situation with its corresponding timeframe for submission of the requested information. If the information is not submitted by the due date then HSM suspends review of the request.

If the review can not proceed because ...	then ...	Review Type	Timeframe for submission
1. Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	<ul style="list-style-type: none"> • Admission • Retrospective 	Three business days.
2. Clinical information is needed by the first level reviewer.	Clinical information required to complete the review is requested.	Admission	Three business days.
		Retrospective	Ten business days.
3. Clinical information is needed by the second level reviewer.	Clinical information required to complete the review is requested.	Admission	One business day.
		Retrospective	Ten business days.

C. Notification of Review Outcome

HSM provides written notification of review results to providers and to beneficiaries or the beneficiary's or youths legal guardian or representative/responsible party when services are not approved as requested. Verbal notification of approvals will only occur if the provider is unable to receive written auto-fax notification. Providers also receive verbal notice of denials.

The DME provider, the attending physician, the beneficiary or youth's legal guardian, or representative/responsible party may request a reconsideration of a denial determination. A second physician, one not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld or modified, the beneficiary or youth/guardian, or representative/responsible party may appeal the decision directly to the Division of Medicaid. See the **Reconsideration Process** section of this manual for additional information.

The following table contains the details of the notification process based on review outcome

Review Outcome	Details
Certification (Approval)	<ul style="list-style-type: none"> Written notification of approval review results is sent to the DME provider and the ordering specialty (physician/physician assistant/nurse practitioner). Verbal notification of approval to the provider will only occur if the provider is unable to receive written auto-fax notification.
Denial	<ul style="list-style-type: none"> If HSM determines that services are not medically necessary and appropriate, a denial letter will be issued and reconsideration rights will apply. Written notification of denial determination is sent to the DME provider, ordering specialty (physician/physician assistant/nurse practitioner) and beneficiary/representative/responsible party. The beneficiary/representative/responsible party's notice does not contain the medical basis for the denial.
Suspended	Written notification is sent to the requester when additional information is required and the review will be pended. If the requested information is not submitted by the due date, then HSM issues a written Notice of Review Suspended.

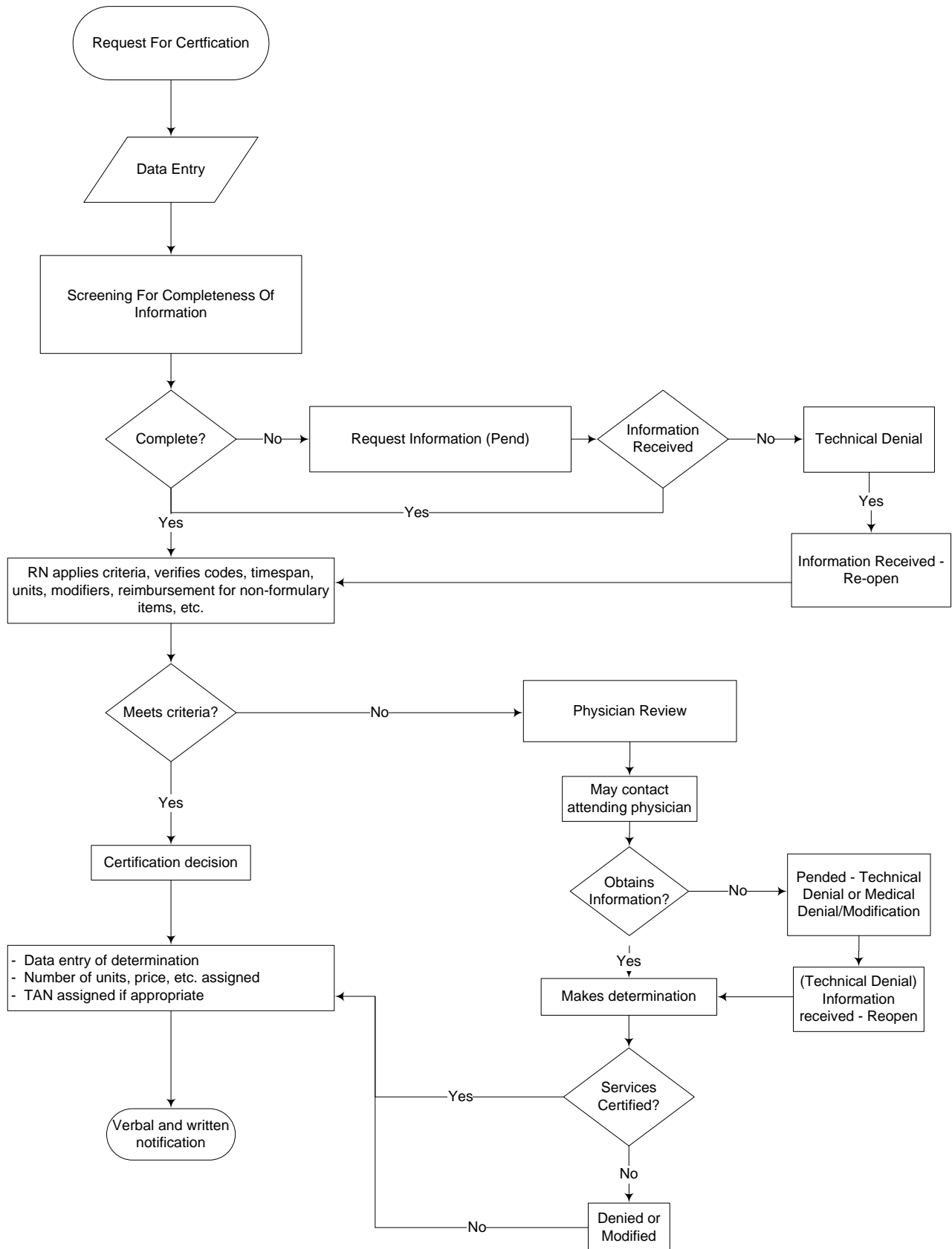
Review determination and notification timeframes are displayed in the following table.

Review Type	Review Determination and Verbal Notification	Written Notification
Admission	Within two business days of receipt of review request and necessary information.	Within one business day of review determination.
Retrospective	Verbal notification is not given for this review type.	Within 20 business days of receipt of review request and necessary information.

Written notifications of review certification (approval) and determinations involving denials are sent to various parties as noted above. Notices of review outcome include the following information.

Review Outcome	Information	Review Type	
		Admission	Retrospective
Certification (Approval)	Date of notice.	✓	✓
	Brief statement of HSM's authority and responsibility for review.	✓	✓
	Reason for determination.	✓	✓
	Date(s) of service being approved.	✓	✓
	Type of equipment/supply certified.	✓	✓
	Number of units certified.	✓	✓
	Assigned reimbursement, if manually priced.	✓	✓
	Treatment Authorization Number (TAN).	✓	✓
Denial	Date of notice.	✓	✓
	Brief statement of HSM's authority and responsibility for review.	✓	✓
	Principal and clinical reason for denial.	✓	✓
	Type of equipment/supplies number of units, and dates of services being denied.	✓	✓
	Process for submitting a reconsideration request.	✓	✓
	Reconsideration timeframes.	✓	✓

D. HSM Review Process Flow Chart



VI. Reconsideration Review Process

If any of the following parties disagree with the determination made by HSM, a request for reconsideration may be requested.

- Beneficiary/legal representative/responsible party.
- DME provider.
- Ordering specialty (physician/physician assistant/nurse practitioner).

A second physician, one not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld, the beneficiary/legal representative/responsible party may appeal the decision directly to the Division of Medicaid.

Please see the ***Reconsideration Process Manual*** for additional details.

VII. Quality Review Process

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving DME services. Quality of care review is conducted through a randomly selected 5% quality sample of cases certified by HSM. HSM identifies aberrant patterns and/or trends by provider.

Please see the ***Quality Review Process Manual*** for additional details.

VIII. Utilization Analysis, Focused Studies, Outcome Reports, and Proposals for Improving Health Care Delivery System

Under contract with DOM, HSM will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.

We look forward to working with DOM and the Medicaid provider community on this endeavor.