

## **Durable Medical Equipment, Orthotics, Prosthetics, and Medical Supplies: Retrospective Review**

### **Objective:**

To determine, on a retrospective basis, the medical necessity and appropriateness of Durable Medical Equipment (DME), Orthotics/Prosthetics (O&P), and Medical Supplies ordered for the designated beneficiary, through the application of medical criteria resulting in a certification decision.

To assign, on a retrospective basis, reimbursement rate(s) using Division of Medicaid (DOM) pricing methodology for DME/O&P/Medical Supply items that do not have assigned fees on the DOM Fee Schedule.

### **Performed By:**

Technical Coordinators (TC)  
Home Health/DME Review Supervisor  
Utilization Review Coordinators (URC) – Registered Nurses  
Physician Advisors (PA)  
Denial/Reconsideration Coordinator (DRC)

### **Policy:**

**Retrospective certification is initiated when the beneficiary was not Medicaid eligible at the time of provision of DME/O&P/Medical Supplies but has since received a retroactive eligibility status.**

HSM conducts retrospective review of cases with dates of service older than one (1) year ONLY in the following situations:

- the beneficiary's Medicaid eligibility was retroactively established and the request for certification was received within one (1) year of the eligibility determination date.
- the beneficiary was determined to be retroactively Medicaid eligible at the time of provision of DME/O&P/Medical Supplies and the DME provider submits proof that the claim was filed with the fiscal agent in a timely manner by submitting the Transaction Code Number (TCN) assigned to the claim.

**NOTE: Cases not meeting the above criteria are not eligible for certification and should not be submitted to HSM for review.**

DME providers request retrospective review by submitting the appropriate HealthSystems of Mississippi Medicaid DME certification request form and documentation relevant to the DME/O&P/Medical Supplies for which certification is requested as soon as the occurrence is identified. Forms are available on the DOM's web site ([www.dom.state.ms.us](http://www.dom.state.ms.us)).

HSM utilizes licensed professionals, Utilization Review Coordinators (URC), who are registered nurses, to make certification decisions unless review by a Physician Advisor (PA) is indicated. The URC applies DOM's Medical Review Policy in the process of certifying requests. DOM's Medical Review Policy (criteria) is available on DOM's web site ([www.dom.state.ms.us](http://www.dom.state.ms.us)). If criteria are not met, the URC must refer the request to a Physician Advisor (PA) for a review determination. Denial determinations may only be rendered at the physician review level.

Retrospective review requests are completed and notification issued within twenty (20) business days from the day HSM receives all necessary information

If items are denied or partially denied, written notification is sent to the beneficiary/representative, the DME provider, and the attending physician/physician assistant/nurse practitioner within the same timeframe. If items are approved, written notification is sent to the DME provider and the attending physician/physician assistant/nurse practitioner.

The beneficiary/representative, DME provider, and the attending physician/physician assistant/nurse practitioner have a right to request a reconsideration of any denial decision. The request for reconsideration may be submitted by telephone, FAX, or mail to HSM within thirty (30) calendar days of the date of the denial notice. Please refer to the *Reconsideration Process Policy and Procedure* of this manual for additional information and the form to use to request a reconsideration.

## **Procedure: Retrospective Review**

### **1. DME Provider Submits Certification Request to HSM**

DME providers request retrospective review by submitting the appropriate Health Systems of Mississippi Medicaid DME Plan of Care certification request form and documentation relevant to the DME/O&P/Medical Supplies for which certification is sought to HSM as soon as the occurrence is identified. HSM's certification request form incorporates the attending physician/physician assistant/nurse practitioner's Certificate of Medical Necessity and replaces DOM's MA-1148 Plan of Care and MA-1103 DME Authorization Request. Forms are available on DOM's website ([www.dom.state.ms.us](http://www.dom.state.ms.us)). Requests may be submitted by FAX or mail.

### **2. Request is Tracked by HSM**

Upon receipt of the request, HSM date stamps all requests received by mail and tracks the request via the internal tracking system. FAXed requests are tracked according to the date printed during FAX transmission. HSM also verifies the "active" status of the supplier's DME provider number. The attending physician/physician assistant/nurse practitioner (if applicable) identification is verified by HSM, including pertinent telephone and FAX numbers.

### **3. Determination of Whether Request Will Be Reviewed**

HSM determines whether review proceeds based on the eligibility findings and the timeframe during which the services were rendered. The following screens and actions are applied:

- If the beneficiary was not eligible during the dates of service, HSM notifies the DME provider via telephone. HSM stamps the original request (*Request Invalid – Patient is not eligible for Medicaid*) and copy the stamped form for our files. The original request is mailed to the DME provider as written notification.
- If the service end date (through date) is more than one (1) year from the review request receipt date, and the beneficiary is retroactively eligible for Medicaid, then HSM verifies the retroactive eligibility status. If the request for review is received within one (1) year of the retroactive Medicaid eligibility determination (fiscal agent add date), processing of the request continues.

If the request was not received within one (1) year of the retroactive Medicaid eligibility determination, HSM notifies the DME provider by telephone, stamp the original request (*Request Invalid – Request Receipt Date Over One (1) Year From Eligibility Determination Date*), and copy the stamped form for our files. The original request is mailed to the DME provider as written notification.

- If the date of service is more than one (1) year old, based on the through date, and the beneficiary is retroactively eligible for Medicaid, HSM determines if the claim was submitted timely (using the TCN). If the claim was timely, HSM proceeds with processing of the request.

If the claim was not filed timely, or if an TCN was not submitted along with the review request, HSM notifies the DME provider by telephone, stamps the original request (*Request Invalid – Dates of Service Over One (1) Year*), and copy the stamped form for our files. The original request is mailed to the DME provider as written notification.

#### 4. Screening of Request When Beneficiary is Medicaid Eligible

If the beneficiary is eligible for Medicaid, HSM determines if the request is reviewable. There are numerous reasons why HSM would not review a request. Each is described below along with the actions to be taken.

**NOTE: If the request is not reviewed by HSM for any reason described below, HSM returns all copies of orders and other documentation submitted by the DME provider with the review request.**

- Duplicate Request – Upon receipt of the request, HSM checks the fiscal agent's history and HSM files to determine what DME/O&P/Medical Supplies have previously been authorized (certified). If the request is a duplicate, HSM notifies the DME provider via telephone. HSM stamps the original request form (*Request Invalid – Duplicate Request*) and copy the stamped form for our files. The original stamped request is mailed to the DME provider as written notification.

- Cases Excluded From HSM's Review For Other Reasons – The DME/Medical Supplies associated with the following services are not to be certified by HSM:
  - ⇒ Home Health certified DME/Medical Supplies
  - ⇒ DME/Medical Supplies provided through physician's offices
  - ⇒ Patients who have applied for Medicaid and the eligibility determination is pending

When requests for these are received by HSM, the DME provider is notified by telephone. The original request form is stamped (*Invalid Request – These Items are not certified through HSM*) and a copy of the stamped request is made for our files. The original stamped request is mailed to the DME provider as written notification.

- Rental Request – Rentals of DME may occur on a monthly or daily basis. The review procedures associated with each type of rental are described below.
  - ⇒ *Monthly Rentals*: A request for rental of an item requires special processing. Equipment may be rented for up to ten (10) months, with the exception of oxygen and oxygen related equipment. When a request for rental is received, HSM checks the fiscal agent's history and HSM files to determine if rental of the equipment has previously been authorized (certified) and whether the allowable rental certification period has expired. The DME provider must assign a modifier of "RR" to the HCPCS code to indicate that the DME is to be rented on a monthly basis.

If additional rental timeframe(s) is not available, HSM notifies the DME provider by telephone. HSM stamps the original request form (*HSM Certification Not Applicable – Equipment has been rented for the allowable ten (10) months. Additional rental is not available. The equipment is considered purchased and is the property of the beneficiary*) and copy the stamped form for our files. The stamped original request is returned to the DME provider as written notification.

If additional rental timeframe(s) is available, HSM proceeds with processing of the request.

- ⇒ *Daily Rentals*: Request for daily rentals or rentals less than thirty (30) days do not require the same processing steps described for monthly rentals. HSM checks the fiscal agent's history and HSM files to determine if rental of the equipment has previously been authorized (certified).

If the request is not identified as a duplicate, HSM proceeds with review of the request. The DME provider must assign a modifier of "KR" to the

HCPCS code to indicate that the DME is to be rented on a daily or partial month basis.

- Coding Validation and Submission of Required Information - The DME provider is required to submit HCPCS codes, specific clinical information (i.e., copy of the attending physician/physician assistant/nurse practitioner order, seating evaluation for custom wheelchairs, sleep studies, etc), and product information for each DME/O&P/Medical Supply requested.

*Missing Codes/Information:* HSM screens the request to ensure that each item is coded, all forms are complete, and required attachments were submitted. If code(s) are omitted or the request is incomplete, HSM notifies the DME provider via telephone, stamp the original request form (*Incomplete Request for Certification – Codes for all items were not submitted AND/OR Incomplete Request for Certification – Incomplete documentation. Please supply the following: [Fill in with specifics of missing information]*) and copy the stamped form for our files. HSM mails the stamped original form to the DME provider as written notification.

⇒ *Incorrect Codes:* If a code has been submitted for each requested item, HSM validates that the code matches the narrative description of the DME/O&P/medical supply. This is important since the cost determines reimbursement for items on the Medicaid Fee Schedule. If the code(s) is incorrect, HSM notifies the DME provider via telephone, stamp the original request form (*Code Submitted Does Not Match the Narrative Description of the Request Item(s) # \_\_\_\_\_*) and copy the stamped form for our files. HSM mails the stamped original form to the DME Provider as written notification.

⇒ *Miscellaneous/Unspecified Codes and Prices:* Miscellaneous/Unspecified codes are assigned to items that do not have assigned HCPCS codes. For each miscellaneous/unspecified, the DME provider is required to include the name of the product, the product number, and name of the manufacturer. A copy of the manufacturer's quote indicating the list/retail price, must also be submitted with the request.

When a request form containing a miscellaneous/unspecified code is received by HSM, HSM screens the form and attachments to ensure that the required information has been submitted.

When an incomplete request form is received by HSM, HSM notifies the DME provider by telephone and stamps the original request form (*Incomplete Request for Certification – Manufacturer's cost quote was not submitted*) AND/OR (*Incomplete Request for Certification – Incomplete documentation*), and copy the stamped form for our files. HSM mails the original request to the DME provider as written notification. **HSM will not accept duplicate miscellaneous/unspecified codes on the same Plan of Care Form (POC).** For instance, providers may submit one (1) POC with multiple miscellaneous/unspecified codes, but the same

miscellaneous/unspecified code cannot be submitted more than once on the same POC.

- **Medicaid Coverage Criteria:** If the beneficiary is retroactively eligible for Medicaid and is twenty-one (21) years of age or older, HSM determines if the item is available for the beneficiary through application of DOM's coverage criteria. If all requested items are not covered, the items are not available through Medicaid and the request is considered invalid. HSM notifies the DME provider via telephone, stamp the original request form (*HSM Certification Not Applicable – Patient twenty-one (21) years or older – Item not available for coverage for this beneficiary*), and copy the stamped form for our files. HSM mails the original request to the DME provider. This constitutes written notification.

In instances where at least one requested item is covered, review of the request proceeds.

⇒ *Modifiers:* If the request has progressed through the above screens/processes, HSM checks each code/modifier submitted by the DME provider to ensure the following: 1) a modifier is present, and 2) the modifier is applicable to the requested item.

If the modifier is missing, HSM notifies the DME provider by telephone. HSM stamps the original request form *Incomplete Request – Modifier required for code # \_\_\_\_\_*) and copy the stamped form for our files. HSM mails the stamped original form to the DME provider as written notification.

If the modifier is not applicable to the code, the DME provider is notified by telephone. HSM stamps the original request form (*Invalid Request – Modifier not applicable to code # \_\_\_\_\_*) and copy the stamped form for HSM's files. The stamped original form is mailed to the DME provider as written notification.

## **5. Handling the Request When Incomplete Information is Received**

If the review request cannot be completed due to a lack of any of the necessary information, the non-clinical Technical Coordinator (TC) verbally notifies the requestor by telephone to obtain the necessary information. The TC attempts telephone contact two (2) times and documents the attempts in the electronic tracking notes screen. The DME provider has three (3) business days to submit the necessary information.

If the information is not received within three (3) business days from the date of verbal notification, the TC stamps the review request (*Lack of Information – Unable to Initiate Review*) and copies the stamped request for our files. HSM mails the original request to the DME provider as written notification that the review cannot be initiated. If review is still necessary, the DME provider must resubmit the review request again and all necessary information to reinstate the review process.

## 6. Request is Complete

Once all screening has been performed and all information is received, the request and all attachments are forwarded to the URC. The review timeframe begins upon receipt of all required information.

## 7. Recheck of Request

Upon receipt of the review request, the URC screens the request to ensure that:

- all required form fields have been completed,
- all required documentation is present,
- HCPCS codes are accurate,
- modifiers are appropriate for the associated code,
- at least one requested item is covered (available) for the beneficiary, and
- the request is not a duplicate.

If the request is incomplete or lacks required documentation/attachments, the request is returned to the DME provider utilizing the processes described above. If the screens described above are “passed”, the URC proceeds to step ten (10).

## 8. URC Requests Additional Information

The URC assesses the request to determine if there is enough clinical information to make a determination. If additional information is needed, the URC requests the information from the DME provider in writing (*Request for Additional Information*) and pends the review. The DME provider has ten (10) business days to submit the requested information.

## 9. Suspension of Review – URC Review Level

If HSM does not receive the requested information within ten (10) business days, the review of the request is suspended. A **Notice of Incomplete Information – Certification Suspended** letter is sent to the DME provider informing the provider that the case has been closed.

At the point the requested information is received, review of the request continues.

## 10. Review of the Request – URC Review Level

Once all available information has been received, the URC performs review of each line item. The URC performs the following activities (in no particular order):

- applies DOM’s Medical Review Policy (criteria) to determine the medical necessity and appropriateness of the proposed DME/O&P/Medical Supplies. DOM’s Medical Review Policy (criteria) is available on DOM’s web site ([www.dom.state.ms.us](http://www.dom.state.ms.us)).
- assigns reimbursement for items not on the Medicaid Fee Schedule
- evaluates the proposed time span of services (from-through dates) and number of units for appropriateness
- verifies the appropriateness of the modifier assigned by the DME provider
- ensures that the ordering physician/physician assistant/nurse practitioner is of the correct specialty

### 11. Approval of The Request –URC Review Level

If the Medical Review Criteria is met and the request is appropriate, the URC approves (certifies) the DME/O&P/Medical Supplies, modifiers, time span (from-through dates), number of units, and establishes/verifies reimbursement for items not on the Medicaid Fee Schedule , and HSM assigns a Treatment Authorization Number (TAN).

Written notification (**DME Notice of Review Outcome**) of the determination is sent to DME provider and the attending physician/physician assistant/nurse practitioner within twenty (20) business days of receipt of all necessary information.

### 12. Referral of The Request for Physician Review

If the medical review criteria are not met, the URC refers the case for physician review.

### 13. Physician Advisor Requests Additional Information (if needed)

The physician examines the request and all available information and, if necessary, contacts the attending physician/physician assistant/nurse practitioner or DME provider to obtain additional information. This communication is initiated via telephone with written follow-up (**Request for Additional Information**) provided on the same day as the telephone request. The case is pended and a period of ten (10) business days is allowed for submission of the requested additional information.

### 14. Suspension of Review – Physician Advisor Level

If the requested information is not received by HSM within ten (10) business days, the case is closed. HSM sends a **Notice of Incomplete Information – Certification Suspended** letter to the DME provider informing the party that the case has been closed.

At the point the requested information is received, physician review continues.

### 15. Review of the Request - Physician Review Level

Upon receipt of a complete referral case, the PA makes a determination based on practice standards, clinical experience and judgment.

If the PA's initial determination is to deny, verbal notification to the agency and/or the physician is made. PAs call the attending physician two (2) times prior to issuance of written denial determination. If no contact occurs because the physician is not available, HSM proceeds with issuance of the denial notification letter to maintain review timeframe completion requirements. During attempted telephone contacts the PA provides verbal instructions and contact information for the attending physician, affording the attending physician an opportunity to discuss the case (peer-to-peer conversation). HSM makes every attempt to arrange a peer-to-peer conversation within one (1) business day of a request with the same PA making the initial determination or as soon as possible.

***NOTE: A peer-to-peer conversation that occurs following issuance of the denial determination notification in no way may change the PA's initial denial determination. If the attending physician continues to disagree with the PA's determination following the peer-to-peer conversation, the attending physician may submit a request for reconsideration to HSM. Please refer to the Reconsideration Policy and Procedure for detailed information on this process***

## **16. URC Completes The Review Process**

If the request is approved, the URC enters the PA's review determinations and completes the notification process outlined in step eleven (11) as described above.

If any item is totally or partially denied, the review is forwarded to the Denial/Reconsideration Coordinator (DRC) who sends written notification (**DME Notice of Review Outcome - Denial**) to the beneficiary/representative, the DME provider, and the attending physician/physician assistant/nurse practitioner within twenty (20) business days of receipt of all necessary information and verbal notification by telephone to the DME provider and ordering physician/physician assistant/nurse practitioner within the same timeframe.

**All DME Notices of Review Outcome (approval and/or denial) includes the following information:**

- description of the DME/O&P/Medical Supplies
- time span (from and through dates)
- number of units
- modifier(s)
- reimbursement amount (for items not on the Medicaid Fee Schedule)
- the Treatment Authorization Number (TAN)
- the review decision, i.e., approved, partial approval, denied, etc.
- the principal and clinical rationale for denial or partial denial if applicable (*only applies to the physician and provider letters*)
- the process for submitting a reconsideration the reconsideration timeframes

## **17. Reconsideration Rights**

The beneficiary/representative, DME provider and the physician/physician assistant/nurse practitioner have a right to request a reconsideration of any denial or partial denial decision. Refer to the *Reconsideration Process* section of this manual for additional information.