

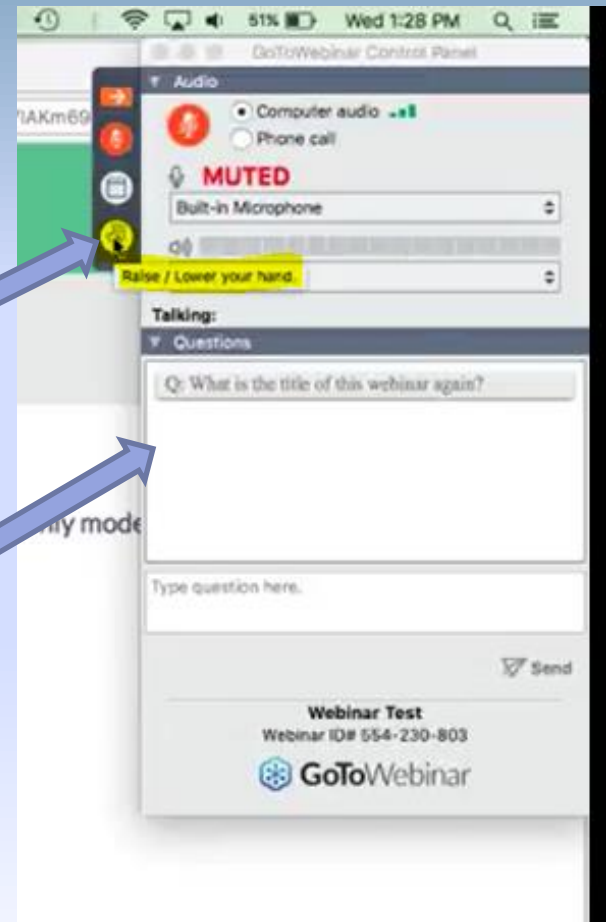
Monthly DME Webinar and Q&A

June 2018:
Lift Chairs

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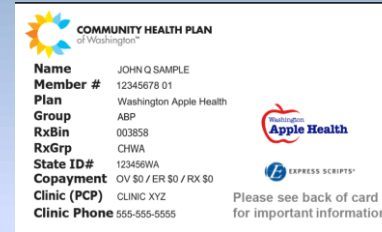
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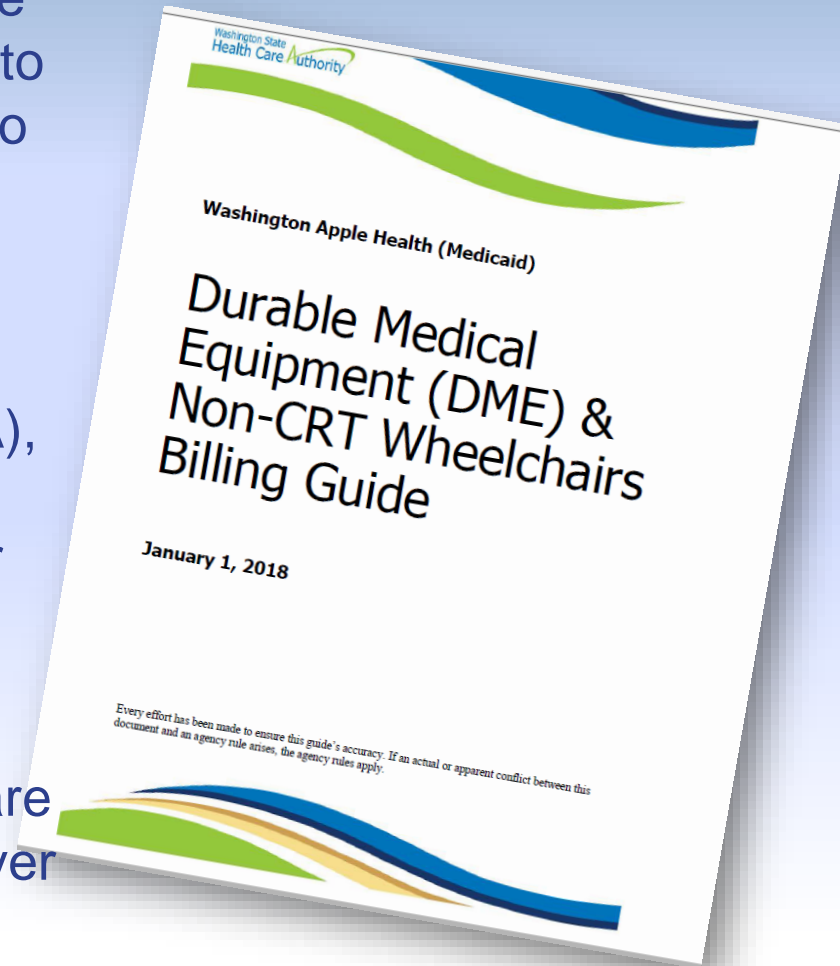
Reminders



- ❖ The client must first coordinate with their health care provider to obtain covered items through Medicare, private insurance, Apple Health or other available benefit.
- ❖ Do not create a social service authorization until all other available funding sources have been exhausted (this does **not** mean a denial is required for every SS authorization).
- ❖ Social service authorizations cannot be used to supplement Medicare or Apple Health rates.
- ❖ Medicare information is provided only as an FYI and represents our understanding of coverage at the time of the webinar.

Reminders

- ❖ It is the DME vendor's responsibility to be aware of the process and forms needed to request a prior authorization, exception to rule (ETR) or limit extension, as needed, under the client's Apple Health (AH) medical benefit.
- ❖ Per their Core Provider Agreement (CPA), DME vendors must exhaust other coverage before submitting a request for payment under a social service authorization.
- ❖ A vendor cannot bill a client for a Medicare "co-pay" or deductible. This is a "crossover claim"; there are instructions in the [DME Billing Guide](#) on how a vendor bills a crossover claim in ProviderOne.



MANAGED CARE AND DME

- If the item and individual are both covered by an Apple Health (AH) managed care benefit, the managed care organization (MCO) is responsible to provide it if the client meets eligibility criteria.
- The DME process may vary for each MCO and may be slightly different than HCA's.
- Each managed care plan has its own network of contracted vendors; most provider websites list their available providers.
- All MCOs cover the same benefits, but it is not required they cover the same brands.
- The contracted DME vendor should work directly with the MCO to obtain covered equipment.
- MCOs have a requirement to simplify their processes; for example, they should not require monthly authorizations for on-going supplies.
- As with other medical plans, if the client is enrolled in an AH managed care plan and it appears the client meets the criteria for the item, the case worker should not create an authorization unless a denial has been verified.
- Just like with HCA, sometimes a denial (rejection) by an MCO is simply due to the plan needing additional documentation. The vendor should supply the case worker a copy of the denial letter prior to a social service authorization being created.

MANAGED CARE

If the individual is covered by a managed care organization (see plans below), the client, family member or physician should contact the plan directly for program benefits.

- [Amerigroup](#)
- [Community Health Plan of Washington \(CHPW\)](#)
- [Coordinated Care of WA](#)
- [Molina Healthcare](#)
- [United Healthcare \(UHC\)](#)

If the vendor or case worker believes the MCO is not being responsive in meeting the client's DME needs, email HCAMCprograms@hca.wa.gov.

DDA: PRIOR AUTHORIZATION

- Payer of last resort
 - DDA is available to pay for all or a portion of DME items but only if Medicare or Medicaid (or other funding sources) have denied the claim.
- With Prior Authorization (a process completed in CARE), DDA can pay for DME without first requiring a denial from Medicare or Medicaid if the item is never covered.
- For Prior Approvals, a Case Manager should:
 - Include a description of need or medical necessity.
 - Include a denial (if applicable).
 - Request approval in advance of the DME purchase.
 - Allow time for the PA request to be processed.

Note Regarding Denials

A denial is not necessary for a DME item that is necessary for independent living for the client and:

1. The client's medical benefit has been exhausted (including requesting a Limitation Extension when available); or
 2. The item is not covered by the client's medical benefit.
- This means for an item that is never covered by Medicaid, a denial is not necessary prior to creating the social service authorization.
 - An AH denial is only necessary if the item is likely to be covered, the client is on Medicaid and the client likely meets AH criteria.
 - A denial is not required if the client clearly does not meet medical necessity criteria.
 - A denial is not required if the client is not on Medicaid.
 - A denial is not required if the item is never covered.

Resource

Find a refresher on basic DME information like blanket codes, HCA exception to rule, prior authorization, etc. plus social service flow charts, reference tools and the latest DME webinar (presented to DME vendors and DSHS/AAA staff) at Health Care Authority's [DME Resource site](#).

Other helpful information can also be found at the site.

Resources

- [DME provider webinar presentation](#)
- [Diabetes supplies](#) (limitation extension request)
- [Bathroom equipment](#) (limitation exception to rule)
- [Compression garments](#) (limitation exception to rule)
- [Incontinent supplies](#) (limitation extension request)
- [Enteral nutrition](#) (exception to rule)
- [Fee-for-service providers of nonsterile gloves](#)
- [General information form](#)

Social service authorizations

- [DME resource guide](#)
- [Lift chair flow chart](#)
- [HCS bathroom flow chart](#)
- [DME flow chart](#)
- [Client responsibility](#)
- [Determining Medicaid coverage in ProviderOne](#)
- [Viewing decisions in ProviderOne](#)
- [Non covered items that may be covered by DSHS](#)

Contact

Email: dme@hca.wa.gov

What is included in the Apple Health DME rate? (WAC 182-543-9000(8))

Apple Health's payment rate for purchased or rented covered DME related supplies, and related services include:

- Any adjustments or modifications to the equipment required within three months of the date of delivery, or are covered under the manufacturer's warranty. This does not apply to adjustments required because of changes in the client's medical condition.
- Any pick-up and/or delivery fees or associated costs (e.g., mileage, travel time, gas, etc.).
- Telephone calls.
- Shipping, handling, and/or postage.
- Routine maintenance of DME including:
 - Testing.
 - Cleaning.
 - Regulating.
 - Assessing the client's equipment.
- Fitting and/or set-up.
- Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

Lift Chair: General

Lift chairs may assist clients to transfer more independently from a seated to a standing position. This increased independence may allow them to remain at home. Need for this DME item must be specified in the client's care plan.

Things to consider:

- When picking a vendor, Lift chairs can only be purchased from Durable Medical Equipment (DME) vendors.
- Does your client have Medicare? Do they meet Medicare's criteria for medical necessity?



Lift Chair: General

Relevant service codes

- 1) **SA419** is the service code for the furniture portion of the lift chair.
- 2) **SA879** covers the initial lift mechanism/motor portion and parts if the device later needs repair.
- 3) **K0739** is used to pay a provider for the cost of labor associated with repairing a device owned by the client.

Lift Chair: Lift Mechanism/Motor

- If a client's case worker determines that a lift chair is ***necessary for independent living***, DSHS will pay for the lift mechanism/motor portion for:
 - Clients not enrolled in Medicare
 - Medicare-enrolled clients after Medicare has denied the vendor's claim*, or
 - Medicare-enrolled clients who do not meet Medicare's medical necessity criteria.
 - The vendor must include the following statement on the quote/bid for the lift chair for client's not meeting Medicare's criteria:
"I attest that [client name], to the best of my knowledge, does not meet Medicare's medically necessary criteria for a patient lift chair."

Lift Chair: Lift Mechanism/Motor

Medicare coverage requires that all of the following criteria must be met:

- The patient must have severe arthritis of the hip or knee or have a severe neuromuscular disease.
- The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the patient's condition.
- The patient must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a patient has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all patients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.)
- Once standing, the patient must have the ability to ambulate.
- Medicare will not cover this item if the beneficiary has a wheelchair, scooter, or power wheelchair on file.

Lift Chair: Furniture Portion

- The furniture portion is never covered by Medicare nor is it covered by Medicaid.
- The maximum amount allowed for the chair portion is \$1800.00. There is no exception to this limit.
- DSHS will cover the furniture portion of a basic lift chair ***if*** the case worker has determined the lift chair is ***necessary for independent living and a prescription (clients enrolled in Medicare) or a prescription/ recommendation (clients enrolled in Medicaid) has been provided by a medical professional.***
- Upgrades in fabric and other add-ons to the chair are not allowed unless it is due to necessity such as needing vinyl fabric for ease of clean-up for client with incontinence issues.

Lift Chair: Process

Reminders

- ❖ Client responsibility/participation applies.
- ❖ Items purchased under this authorization must be of direct medical and remedial benefit to the client.

Lift Chair: Process

Client is enrolled in Medicare and client meets Medicare's medically necessary criteria:

NOTE: Per Medicare policy, the chair must be delivered prior to billing.

1. When Medicare covers a lift mechanism, it is not covered at 100%. The case worker should create a social service authorization as follows:
 - ❖ SA879 (in “reviewing” status) for the lift mechanism/motor portion; and
 - ❖ SA419 (in “reviewing” status) for the furniture portion of the basic lift chair.
2. When the balance owed on the lift mechanism is confirmed or if Medicare denies the claim for the lift mechanism (since the client has already received the lift chair) the status of SA879 and SA419 needs to be changed to “Approved” **and** the rates need to be updated so the vendor can claim and be paid.
3. The case worker should submit a Social Service Packet Cover Sheet to DMS with the **invoice** from the vendor attached using Hotmail.

Lift Chair: Process

Client enrolled in Medicare and the client does not meet Medicare's medically necessary criteria:

1. If the vendor attests that the client does not meet Medicare's medically necessary criteria and the case worker has received a recommendation from a health care professional, create social services authorization using:
 - ❖ SA879 (in "reviewing" status) for the lift mechanism/motor portion; and
 - ❖ SA419 (in "reviewing" status) for the furniture portion of the basic lift chair.
2. After the case manager has confirmed with the client/representative that the lift chair has been delivered, the status of SA879 and SA419 needs to be changed to "Approved" so the vendor can claim and be paid.
3. The case worker should submit a Social Service Packet Cover Sheet to DMS with the invoice from the vendor attached using Hotmail.

Lift Chair: Process

Medicaid only authorizations (client is not enrolled in Medicare):

1. Create an authorization using:
 - ❖ SA879 (in “reviewing” status) for the lift mechanism/motor portion; and
 - ❖ SA419 (in “reviewing” status) for the furniture portion of the basic lift chair.
2. After the case manager has confirmed with the client/representative that the lift chair has been delivered, the status of SA879 and SA419 needs to be changed to “Approved” so the vendor can claim and be paid.
3. The case worker should submit a Social Service Packet Cover Sheet to DMS with the invoice from the vendor attached using Hotmail.

Lift Chair: Repair Process

When a client needs their lift chair repaired the provider can be paid for the cost of the parts (SA879) and their labor time for completing the repair (K0739).



The lift mechanism is considered medical equipment and the appropriate service code(s) must be authorized and billed.

CARE RELEASE NOTE

- SA419 is currently not able to be put in “reviewing” status. During the 6/29/18 CARE release, SA419 (Lift Chair furniture portion) will be able to go into reviewing status to align with the instructions found here and in the SCDS.

FAQ

Q: My client has Medicare but Medicare won't cover the entire cost of the lift mechanism. Can social services pay for part of the Medicare covered lift mechanism?

A: Yes. Typically Medicaid would pay for a client's Medicare co-pay or cost share fee. Because lift chairs are NEVER covered by Medicaid, a social service authorization is allowed to pay for this under SA879. This is not supplementing the rate; it is covering the deductible or co-pay.

FAQ

Q: The provider says that they will only bill SA421 and SA626. Can we use these codes?

A: That depends. If the vendor is repairing the furniture (non-medical) portion of the lift chair (fabric, wood frame, cushion) you could use SA421 and SA626. If the vendor is repairing the motor/lift mechanism/hand controls then you must use SA879 and K0739.



Q&A from Webinar

Question	Answer
<p>Can a client private pay for lift chair upgrades (i.e. heat, massage, etc.)?</p>	<p>Yes. The client can private pay for upgrades, however, this is an agreement between the client and the vendor. The upgrades cannot be a part or line item of any social service price quote or invoice.</p>
<p>Would a lift chair upgrade void client's ability to have the chair repaired in the future?</p>	<p>If a repair is needed for the lift mechanism/motor then the client will be eligible for that repair in the future. If a repair is needed for the upgraded feature this is NOT covered.</p>
<p>What if the vendor must travel over 60 - 120 minutes to go to the DME needing repair, can mileage/time be covered through ETR?</p>	<p>No. Medicare/Medicaid rules specify that the negotiated rates include travel time/assessment costs and these cannot be charged separately.</p>
<p>If the cost of the chair is more than the DME limit, is an ETR necessary?</p>	<p>Yes, a CM should staff the case with their supervisor and process a local ETR if the cost exceeds the DME limit.</p>

Q&A from Webinar

Question	Answer
Can a provider add the cost of shipping to the price of an item.	Shipping costs are included in the negotiated rate for medical supplies and cannot be added as a separate line item. There are specific instructions that allow for the addition of a shipping fee for non-medical equipment and supplies .
Can a provider repair a chair they did not supply?	Yes, as long as the vendor has a DME core provider agreement with HCA they can repair a lift chair owned by the client and purchased elsewhere.
Is a recommendation from a physician sufficient or do we need an OT/PT evaluation?	As of this webinar an OT/PT eval is not necessary. If this changes we will update these instructions.
What is the warranty for a lift chair?	Medicare and SS do not offer a warranty, the warranty is from the manufacturer.
Should the lift chair price quote and invoice be itemized?	It is easier for the case worker to create the social service authorization if the price quote and invoice were itemized.

Q&A from Webinar

Question	Answer
Does DDA policy require an OT/PT eval to authorize the purchase of a lift chair?	Yes. DDA policy requires that an OT/PT referral be provided for the purchase of DME; reference should be made to the DME improving a person's ability to perform ADLs and IADLs."
If the only vendor willing to service our client is far away can they charge a shipping fee?	No. The rates for DME include shipping. The provider can decline to serve a client if the client is "outside of their service area".
My vendor is saying that there is a shipping fee allowed for Medicare supplied equipment, is this true?	No. The DME rate for an item covered by Medicare or Medicaid includes delivery/setup/instruction on use.
Does a physician have to have a face to face visit to write a referral for a lift chair?	This is not presently (6/2018) a requirement nor is it something the provider can indicate when submitting a claim in P1. There is a Federal rule in process regarding this but that information is not yet available.

Q&A from Webinar

Question	Answer
<p>I thought social services can't supplement Medicare or pay a Medicare co-pay.</p>	<p>Apple Health Medicaid typically covers a client's Medicare co-pay. Lift chairs and their motor are unique because they are NEVER covered by Medicaid, therefore social services can pick up this co-pay or deductible.</p>
<p>What should we do if a physician declines to provide documentation or a referral for the client to obtain items we think may be necessary for independent living or items that the client previously received and is dependent upon?</p>	<p>Physicians may decline to write a referral if they feel they client would not longer benefit from a particular item or if the item would worsen the client's condition.</p> <p>If a prescription or chart notes document a need, the client can request the medical records from their physician's office. If the client needs new documentation they may need to consider going to a different provider.</p>

Resources

- DME Webinar Series posted here:
<http://intra.alsa.dshs.wa.gov/training/DME/>
- DME Provider Billing Guide
- DME Fee Schedule
- Social Service Blanket Code to HCPCS Crosswalk
- Medicare Supplier Directory
- Noridian [Medicare's DME claims administrator site where you can find a list of Medicare covered and non-covered items (WA is in Jurisdiction "A").]
- For issues with Medicare's Competitive Bid area or winning bidders or other Medicare concerns call CMS: (800) 633-4227