

# Monthly DME Webinar and Q&A

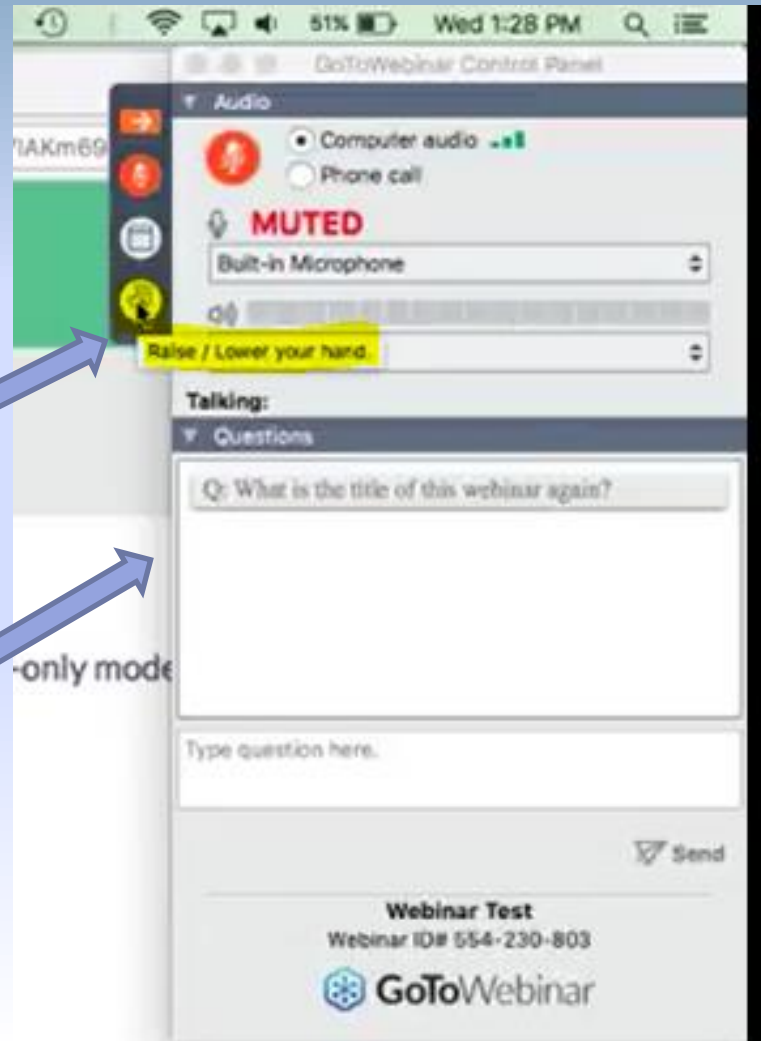
April 2018:

## Wheelchairs and Walkers

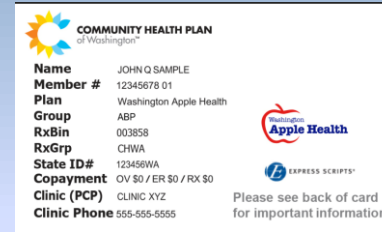
You are currently muted.

If you would like to be unmuted for the Q&A, please raise your virtual hand when indicated.

Or you can type your question in the question panel.



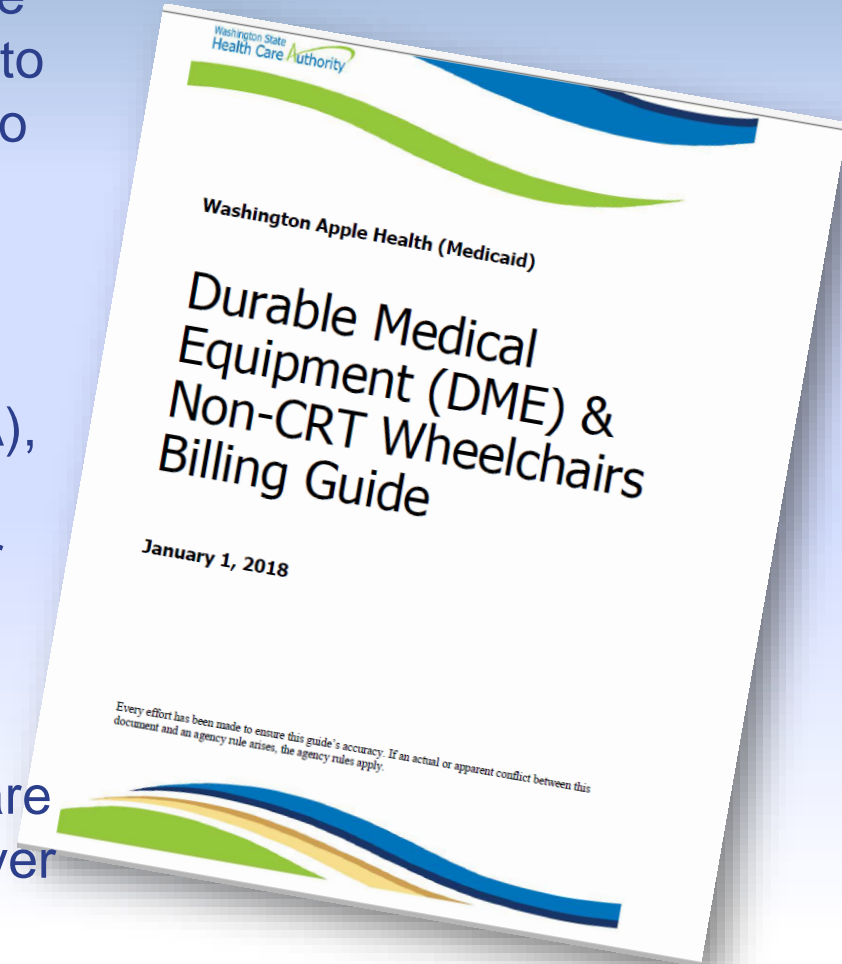
# Reminders



- ❖ 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](mailto: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.

# 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](mailto:dme@hca.wa.gov)



# Walker/Rollator: Medicare

The vendor works with the client and PCP. Wheelchairs are subject to the competitive bid program (only applies when the client has Medicare coverage and meets Medicare's criteria). Included are:

- Vancouver (Clark and part of Skamania Counties)
- Seattle-Tacoma-Bellevue (includes Snohomish Co.)

A walker (which includes rollators) and related accessories may be covered under a Medicare benefit when the client's mobility issue:

- Prevent a "mobility-related activity of daily living" (MRADL); or
- There is a risk of morbidity or mortality; or
- Prevents an MRADL within a reasonable timeframe (such as not being able to reach a bathroom in a timely way).
- These issues must impair MRADLS within the home.
- The individual must be able to safely use the equipment.
- The mobility issues must be resolved with the equipment.

MRADL examples include:

- Toileting
- Feeding
- Dressing
- Grooming
- Bathing



# Walker/Rollator: Medicare

## **The vendor works with the client and PCP.**

Some HCPCS codes for walkers/rollators come “bundled” and include brakes. There should be no additional “add-on” expenses when the item is bundled. However, covered rollator brakes are a glide style brake. Most people prefer bicycle style brakes, which have their own HCPCS and are not covered by Medicare.



## **Clients with both Medicare and Medicaid (dually eligible individuals):**

When a client meets Medicare’s criteria for a walker or rollator, but the preferred bicycle style brakes are not covered:

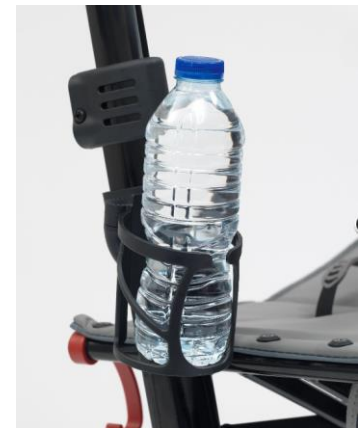
- The vendor follows Medicare’s process to supply the walker/rollator but uses Medicare’s HCPCS code for non-covered items when they claim the brakes (A9270-for Medicare use only).
- The vendor submits a PA for the brakes in ProviderOne, including in the Comments section (Box 30) that that item is not covered by Medicare (or was denied).
- If AH denies the PA, a SS Authorization can be created for the brakes by following all social service authorization procedures for DME.
- Purchasing additional parts for a standard piece of equipment such as a walker or rollator, when necessary, is not considered supplementing the rate.



# Walker/Rollator: Apple Health

**The vendor works with the client and PCP.**

- When a client meets Apple Health criteria, AH covers one walker/rollator per client in a five year period with no prior authorization required. Replacement parts, such as tips, can also be replaced without a PA.
- If a client's walker is lost, stolen or damaged and the individual needs a replacement sooner than 5 years, the vendor can request a Limit Extension from AH.
- AH may pay for add-ons like a brake upgrade or a seat when not covered by Medicare (see previous slide). AH will not pay for accessories like custom seat, carrying bag or cup holder (examples below).



# Walker/Rollator: Social Service

**The vendor works with the client and PCP with additional involvement by the case worker.**

- An AH denial must be obtained for a walker/rollator prior to a SS authorization being created.
- When a social service authorization is created for a walker, rollator or for necessary parts or accessories, the blanket code is: **SA880 (Mobility Aids and Supplies)**.
- The vendor should dispense the item as prescribed by the PCP. There should be no additional charges to the client.

Example: a client has a prescription for a 4 wheel walker but the vendor is trying to charge an additional fee for the 4 wheels, relative to a 2 wheel walker. If the physician prescribed a 4 wheel walker then the vendor needs to bill primary payers for a 4 wheel walker.

However, if the physician prescribed a 2 wheel walker and the client is requesting 4 wheels, *that is be considered personal preference and DSHS cannot pay the difference.*

# Questions about rollators or walkers?



Please raise your “hand” for us to unmute you,  
or type your question in the question or chat pane.

# Wheelchair: Medicare

## The vendor works with the client and PCP. General Information:

- Wheelchairs are subject to the competitive bid program (only applies when the client has Medicare coverage and meets Medicare's criteria). Included are:
  - Vancouver (Clark and part of Skamania Counties)
  - Seattle-Tacoma-Bellevue (includes Snohomish Co.)
- Criteria: must meet mobility limitation requirements, which generally include:
  - Mobility limitations that impair mobility related activities of daily living (MRADLs)
  - Mobility limitations cannot be sufficiently resolved with a cane or walker.
  - The home/setting provides adequate access between rooms, maneuvering space and surfaces.
  - Manual wheelchair (MWC) will improve beneficiary's ability to participate in MRADLs and will use it routinely in the home.
  - The client has not expressed an unwillingness to use an MWC.
  - The client has sufficient upper extremity function and other physical and mental capabilities to safely self-propel MWC at home in a typical day.
  - The client has a caregiver or informal support available, willing and able to provide assistance with MWC.
  - MWCs solely for use outside the home will be denied as non-covered.
  - Additional criterion must be met for specialty MWCs to be covered.

# Wheelchair: AH Medicaid

## **The vendor works with the client and PCP. General Guidelines:**

- Requires the vendor request a prior authorization (PA; for purchase, rental and repair), following all instructions in the [DME Billing Guide](#) or follows the client's managed care plan's instructions for a PA.
- When AH determines that a wheelchair will be medically necessary for 6 months and the client lives at home, the agency **rents a wheelchair**. AH considers rented equipment to be purchased after twelve months' rental unless the equipment is restricted as rental only.
- The [DME Billing Guide](#) provides medical criteria for different types of wheelchairs, including when a power-driven wheelchair is covered.
- Specialty cushions and cushion replacements must be requested through the PA process.

# Wheelchair: AH Medicaid, con't

**The vendor works with the client and PCP. General Guidelines:**

- WAC [182-543-4200](#) describes:
  - ❑ When a power-driven wheelchair is covered: client's medical condition negates the ability self-propel a manual wheelchair, the client can safely and independently operate a power-drive WC and the power-drive WC will provide the client the only means of independent mobility.
  - ❑ A second, manual wheelchair may be covered for an individual who has a power-driven WC when the architecture of the home is unsuitable for power-drive WC due to narrow hallways, insufficient turning radius, prohibits access to bathroom, or the power-drive WC cannot be transported to meet clients community activities (that are at least .25 miles from the client's home) and there is no other viable options for transportation (cabulance, public buses or personal transit).
- AH pays to maintain wheelchairs it has approved for non-institutionalized clients.
- AH will pay for one manual or PDWC or repair an existing WC/PDWC for clients who reside in a skilled nursing facility with PA when it will be for the exclusive use of the resident.
  - ❑ The SNF must provide a house WC as part of the per diem rate. A purchased WC/PDWC is not included in the SNF per diem.
  - ❑ For dually eligible clients, AH does not purchase/rent a wheelchair when the client is in the SNF under a Medicare benefit.



# Wheelchair: Social Service

**The vendor works with the client and PCP with additional involvement by the case worker.**

- Most wheelchairs will be purchased through a client's medical benefit but there are occasionally reasons why a social service authorization would be created for a wheelchair.
- A wheelchair requires a denial from the client's medical benefit(s) before pursuing a social service authorization.
- A social service authorization should not be created solely because of a denial. There is often a covered item that is considered same/similar to the denied item.
- Transport chairs are not considered wheelchairs and are never covered by Apple Health.
- The blanket code for wheelchairs is SA886 (Wheelchairs and Accessories).

# Wheelchair: Repairs, Accessories and Modifications

- Repairs or replacement parts are likely covered by the benefit that purchased the original wheelchair. A prior authorization is required for AH Medicaid.
- When a repair or replacement part is denied, a social service authorization may be created. Authorize a repair in the following manner:
  - Authorize **K0739 for the labor**, and
  - Authorize the appropriate blanket code of the item for the parts (for wheelchairs that is **SA886**).
- If a medical benefit does not cover an accessory, additional consideration should be given as to why it is not covered before creating a SS authorization.

1. Questions about wheelchairs?
2. Other DME questions?



Please raise your “hand” for us to unmute you, or type your question in the question or chat pane.

# Resources

- [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](#)

Next DME Webinar:  
May 10, 2018

# Rentals, Repairs & Replacement Parts

GoTo Webinar invitation to be sent soon!