

Medicaid Funded Durable Medical Equipment, Specialized Equipment and Supplies and Bathroom Equipment

2017

NOTE: this information does not include authorization information for
the Medicaid Transformation Project

Understanding Policy: The Payment Hierarchy

- ❖ Providers are required to bill other payment sources before claiming payment through Apple Health or a social service authorization.
 - Private insurance, Medicare, Apple Health (AH/Medicaid) or other available coverage must be used prior to a social service authorization.
 - DSHS and waiver programs are always the payer of last resort.
- ❖ Providers must not request additional payment through a social service authorization or private funds in an effort to supplement the Medicare or AH reimbursement rate.
- ❖ A social services authorization must not be created solely because the vendor says the medical reimbursement rate is too low.

The implementation of ProviderOne Phase 2 in 2015 brought functionality for authorizations and claims that enforce rules and policies.

Understanding Policy

❖ Reminders about “last resort”:

- The vendor must first bill private insurance (third party liability-TPL) or Medicare when the individual and item are covered.
- When the client has Apple Health (AH) coverage and the item is a covered benefit or is “typically not covered”, last resort:
 - Means the vendor must follow all required processes to authorize DME through HCA’s DME process which may include requesting a Prior Authorization (PA), Exception to Rule (ETR), or Limitation Extension (LE) when necessary as detailed in this presentation (for “typically not covered” items such as bathroom equipment, an ETR from HCA is only necessary when the item is likely to be covered by AH).
 - Does not mean that an administrative hearing must be requested for every denial from Apple Health. Hearings should only be requested when it is believed the client meets Apple Health’s criteria, but the equipment was denied.

Understanding Policy

❖ Among the list of items that are not covered by Medicaid per HCA [WAC 182-543-6000](#), there are two types that AL TSA/DDA may cover:

- a) Specific **durable medical equipment** (DME) and supplies (e.g. transfer benches, bath equipment including grab bars, shower benches and commodes, etc.). WAC lists these items as “never covered” however, many of these items **may be** covered by a Medicaid benefit if the client meets exceptional criteria (via an ETR granting an exception to this rule). These items may be subject to an ETR.
- b) **Non-medical equipment and supplies** (e.g. reachers, sock aids, handheld shower). We will refer to these items as specialized equipment and supplies (SES). These are considered “**excluded**” items because they are never covered by AH and they are never subject to an ETR.

Determining Medical Coverage

Available is a reference guide to assist DSHS staff and providers know if a client has:

- Private Insurance (third party liability)
- Medicare
- Apple Health Managed Care
- Apple Health through HCA

This was included in the reference tools that were emailed to you.

What are shared services?

The term “shared services” refers to a medical service that is available through Apple Health and RCL or a DSHS waiver.

Shared services include:

HCS Shared Services		DDA Shared Services	
Proc/ Svc Code	Proc/Svc Code Description	Proc/ Svc Code	Proc/Svc Code Description
SA875	DME: Bathroom aids, toileting, and supplies	SA875	DME: Bathroom aids, toileting, and supplies
SA876	DME: Communication devices and supplies	SA876	DME: Communication devices and supplies
SA877	DME: Diabetic equipment and supplies	SA877	DME: Diabetic equipment and supplies
SA878	DME: Hospital beds and supplies	SA878	DME: Hospital beds and supplies
SA879	DME: Miscellaneous	SA879	DME: Miscellaneous
SA880	DME: Mobility aids and supplies	SA880	DME: Mobility aids and supplies
SA881	DME: Nutrition equipment and supplies	SA881	DME: Nutrition equipment and supplies
SA882	DME: Orthotic equipment and supplies	SA882	DME: Orthotic equipment and supplies
SA883	DME: Ostomy care	SA883	DME: Ostomy care
SA884	DME: Respiratory equipment and supplies	SA884	DME: Respiratory equipment and supplies
SA885	DME: Urinary/incontinence equipment	SA885	DME: Urinary/incontinence equipment
SA886	DME: Wheelchairs and accessories	SA886	DME: Wheelchairs and accessories
SA887	DME: Wound care	SA887	DME: Wound care
SA888	Physical Therapy (RCL/WA Roads only)	SA888	Physical Therapy
SA889	Occupational Therapy (RCL/WA Roads only)	SA889	Occupational Therapy
SA890	Nutrition Services (RCL/WA Roads only)	90863	Medication Management, Psychiatric
SA892	Speech/Hearing/Communication Evaluation (RCL/WA Roads only)	SA892	Speech/Hearing/Communication Evaluation
92507	Speech/hearing Therapy (RCL/WA Roads only)	92507	Speech/hearing Therapy
		SA893	Hearing Hardware (coming soon!)

Shared Services: Who pays for DME?

- ❖ In order for ProviderOne to pay claims for DME, the provider *must* be Medicare enrolled (this may be different for providers of other shared services).
- ❖ When shared services are claimed, ProviderOne first checks to see if the service could be covered by Medicare and if the client has Apple Health coverage.
- ❖ If the client has Medicare coverage and the item/service is covered by Medicare, ProviderOne will not pay unless:
 1. The provider submits verification of a Medicare denial with their billing (Medicare Explanation of Benefits or EOB); or
 2. Attests that the client does not meet Medicare’s criteria for the item on their claim (use “Box 30” on HCA’s General Information form 13-835).

Medical Information			
Diagnosis Code	27	Diagnosis name	28
Place of Service Code	29		
30. Comments:			

Please fax this form and any supporting documents to 1-866-668-1214.

Competitive Bidding: Medicare only

Case workers: The information regarding competitive bidding for Medicare covered clients is for your information only; no follow up is necessary. You may hear from a client with Medicare coverage that a vendor was unable to fill their order for a wheelchair, for example. This section explains why this may occur.

- ❖ Under the program, a competition among suppliers who operate in a particular competitive bidding area (CBA) is conducted.
- ❖ During the compete phase, suppliers are required to submit a bid for selected products.
 - Not all products or items are subject to competitive bidding.
 - Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards.
 - Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount.
 - In 2016, additional items were added to the list of products covered under the competitive bid.

Competitive Bidding: Medicare only

Items that must be purchased by the winning bidder through the competitive bidding process for clients with Medicare coverage include such things as those found in this screen shot.

Competitive Bid Categories ⓘ

Mail-Order Diabetic Supplies ★ [View Examples](#)

- Mail-Order Diabetic Supplies

Enteral Nutrients, Equipment and Supplies ★ [View Examples](#)

- Enteral Nutrients

General Home Equipment and Related Supplies and Accessories ★ [View Examples](#)

- Commodes, Urinals, Bedpans
- Hospital Bed
- Patient Lifts
- Seat Lift Mechanisms
- Support Surfaces (Group 1 & 2)

Nebulizers and Related Supplies ★ [View Examples](#)

- Nebulizers and Related Supplies

Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies and Accessories ★ [View Examples](#)

- NPWT Pumps and Supplies

Respiratory Equipment and Related Supplies and Accessories ★ [View Examples](#)

- Continuous Positive Airway Pressure (CPAP) Devices
- Oxygen Equipment and Supplies
- Respiratory Assist Devices (RADs)

Standard Mobility Equipment and Related Accessories ★ [View Examples](#)

- Power Operated Vehicles (Scooters)
- Walkers
- Wheelchair Seating/Cushions
- Wheelchairs (Standard Manual)
- Wheelchairs (Standard Power)

Transcutaneous Electrical Nerve Stimulation (TENS) Devices and Supplies ★ [View Examples](#)

- TENS Devices and Supplies

The entire US is in a CBA for mail order diabetic supplies (Medicare clients can get them from a local pharmacy, but if they prefer mail order, they must use the winning bidder).

Competitive Bidding: Medicare only

Washington State has Zip Codes which are included in two CBA's:

- ❖ Vancouver (Clark and part of Skamania Counties)
- ❖ Seattle-Tacoma-Bellevue (includes Snohomish County)
- ❖ NOTE: additional Zip Codes may be added in the future.

To verify if a zip code is within a CBA and to see which vendors have been awarded the bids in an area for specific equipment and supplies go to the [Medicare Supplier Directory](#) at [Medicare.gov](#) and type in the Zip Code. The results will also show which items are included in the CBA.

Find a Supplier

Your ZIP code

98134

Go

Categories

This ZIP code is within a Competitive Bidding Area (CBA).

Important: Some competitive bid categories have very similar names marked with a ★. If you aren't sure which category to choose, select list of equipment and supplies included in the Competitive Bidding Proc select the appropriate category from the Non-Competitive Bid Category

Note: Competitive bid supplier information is updated on a weekly basis

Select up to 5 categories, and click the "Search" button below

Supplier Directory Results

KEY Competitive Bidding Program Accepts Medicare Assignment

Your search results for ZIP code 98134 are displayed below.

Important: Use the contact information below to place an order with a Medicare contract supplier (identified with a). Contract suppliers are required to provide competitive bid equipment and supplies (identified with a) throughout the entire competitive bidding area. Medicare's payment for the equipment includes delivery, set-up, and patient training.

If you have additional questions, please call 1-800-MEDICARE (1-800-633-4227).TTY users should call 1-877-486-2048 .

Show All Results

Hide All Results

Print All Results

▼ Hospital Bed (11 results)

Viewing 1 - 10 of 11

<< 2 >>

Supplier Information	Distance	Manufacturers & Models Available
NORCO, INC. / NORCO INC 4135 STONE WAY N SEATTLE, WA 98103 (206) 547-2200 No toll-free number provided View More Locations Map and Directions	6.78 Miles	View Manufacturers and Models
BELLEVUE HEALTHCARE II INC / BELLEVUE HEALTHCARE II INC 2112 118TH AVE NE BELLEVUE, WA 98004 (425) 451-2842 No toll-free number provided View More Locations Map and Directions	9.89 Miles	View Manufacturers and Models
CENTENNIAL MEDICAL EQUIPMENT INC / ROTECH 1000 SW 7TH STREET SUITE F RENTON, WA 98057 (253) 926-0474 No toll-free number provided Map and Directions	12.49 Miles	View Manufacturers and Models
NORTHWEST HOME MEDICAL INC / MEDEQUIP SERVICES 2329 WHEATON WAY BREMERTON, WA 98310 (360) 479-8811 No toll-free number provided	16.69 Miles	View Manufacturers and Models

Competitive Bidding: Medicare only

Vendors in an area covered by the CBA that were not awarded the bid for an item that is included in competitive bidding must inform clients with Medicare coverage that they are not able to supply the equipment or supplies and that the client must work with the winning supplier to obtain the needed item **when the item and the client is covered by Medicare.**

The client may need assistance in determining the vendor with the winning bid by looking at the [Medicare Supplier Directory](#).

Competitive bid ONLY applies to:

- Specific counties for specific Medicare covered items.
- Medicare enrollees who meet Medicare's criteria for the item.

Keep in mind:

- The prescription won't automatically go to the winning bidder because physicians may not know who the winning bidder is.
- If a vendor who is not the winning vendor is contacted, they must refer the individual to the winning bidder.

A field with an asterisk (*) before it is a required field.

* Your ZIP code

98023

Categories

This ZIP code is within a Competitive Bidding Area (CBA).

Important: Some competitive bid categories have very similar names to non-competitive bid categories. Competitive bid categories are marked with a ★. If you aren't sure which category to choose, select "View Examples" next to the Competitive Bid Category. You'll get a list of equipment and supplies included in the Competitive Bidding Program for that category. If your equipment or supply isn't listed, select the appropriate category from the Non-Competitive Bid Categories section below.

Note: Competitive bid supplier information is updated on a weekly basis.

Select up to 5 categories, and click the "Search" button below.

Competitive Bid Categories ⓘ

Mail-Order Diabetic Supplies ★ [View Examples](#)

Mail-Order Diabetic Supplies

Enteral Nutrients, Equipment and Supplies ★ [View Examples](#)

Enteral Nutrients

General Home Equipment and Related Supplies and Accessories ★ [View Examples](#)

Commodes, Urinals, Bedpans

Hospital Bed

Patient Lifts

Seat Lift Mechanisms

Support Surfaces (Group 1 & 2)

Nebulizers and Related Supplies ★ [View Examples](#)

Nebulizers and Related Supplies

Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies and Accessories ★ [View Examples](#)

NPWT Pumps and Supplies

Respiratory Equipment and Related Supplies and Accessories ★ [View Examples](#)

Continuous Positive Airway Pressure (CPAP) Devices

Oxygen Equipment and Supplies

Respiratory Assist Devices (RADs)

Standard Mobility Equipment and Related Accessories ★ [View Examples](#)

Power Operated Vehicles (Scooters)

Walkers

Wheelchair Seating/Cushions

Wheelchairs (Standard Manual)

Wheelchairs (Standard Power)

Transcutaneous Electrical Nerve Stimulation (TENS) Devices and Supplies ★ [View Examples](#)

TENS Devices and Supplies

Non-Competitive Bid Categories

Remember, a case worker does not create an authorization for items covered by Medicare; this is coordinated through the client's medical provider.

Shared Services: Finding Providers

<https://fortress.wa.gov/hca/p1findaprovider/>

ProviderOne Find a Provider

City or County* City County

Specialty*

Subspecialty

Provider or Clinic Name

* indicates required field

If you have difficulty finding a qualified provider and your JRP or Payment Coordinator cannot help, please contact any of the program managers listed on the last slide of the presentation.

Appearing on *Durable Medical Equipment and Medical Supplies* list just means the provider can bill for reimbursement for DME from HCA (but they may not be a DME vendor).

FIND A PROVIDER LIST

Thurston County: Durable Medical Equipment & Medical Supplies

These are the names and numbers of some of our contracted providers. You will need to ask them if they are taking new Washi Health Care Authority is not an insurance company. We are not able to refer you to providers. If you are having problems findir able to get assistance with transportation to a nearby city to see a participating provider.

Provider Name	Phone Number	Address
APPLE PHYSICAL THERAPY-OLYMPIA	(360) 709-0700	3015 LIMITED LN NW #B OLYMPIA, WA 98502
APRIA HEALTHCARE LLC	(360) 352-1753	405 BLACK HILLS LN SW STE A OLYMPIA, WA 98502
BELLEVUE HEALTHCARE II INC SOUTH SOUND	(360) 438-2955	4500 PACIFIC AVE SE STE B LACEY, WA 98503
CUSTOM CARE SOLUTIONS LLC	(360) 753-7224	204 QUINCE NE #100 Olympia, WA 98506
FASA Family Wellness PLLC	(360) 400-3338	201 TAHOMA BLVD SUITE 208 YELM, WA 98597
FASA Family Wellness PLLC	(360) 753-4861	1610 BISHOP RD SW STE 101 TUMWATER, WA 98512
FASA Family Wellness, PLLC	(360) 943-1400	2964 LIMITED LN NW STE B OLYMPIA, WA 98502
Foot & Ankle Surgical Associates PLLC	(360) 400-3338	201 TAHOMA BLVD SE STE 208 YELM, WA 98597
Geneva Woods Health Supplies	(360) 357-2282	406 YAUGER WAY SW STE C OLYMPIA, WA 98502
Geneva Woods Health Supplies	(360) 456-5475	6149 MARTIN WAY E LACEY, WA 98516

The “Find a Provider” DME List includes providers who may not provide DME for a social services authorization (such as a medical clinic, surgery center or pharmacy).

DME vendors with a Core Provider Agreement (CPA) can provide services anywhere in the state or provide mail order services, if they choose. Many have chosen a specific geographic area they cover. You can call a vendor to find out what areas of the state they cover or if they do mail order.

Finding a DME provider

Q: Can a case worker order DME online from places like Amazon*?

A: No; DME requires a contract to be in place so those cannot be ordered via Amazon or other online stores. You must use a vendor with a Core Provider Agreement (CPA) with HCA for these items.

*Client's on New Freedom can have their financial management services (FMS) order DME online.

Finding a DME provider

Q: Can a case worker order **Specialized Equipment and Supplies (SES: non-medical equipment) online or make purchases at a store?**

A. Yes, using one of the two following methods (Note: SES only):

1. Specialized equipment and supplies (SES) such as a reacher or handheld shower, can be purchased from a store or ordered from online vendors such as Amazon using a PCard authorized for client purchases (currently an option for HCS only).
 - a. Include sales tax in the authorization.
 - b. For items ordered online: if an item is being shipped to the client and there is a shipping/handling fee, include the shipping charge in the authorization and make a note of it in the Comments section of the authorization:

The screenshot shows a software interface with three tabs: 'Header', 'Comments', and 'Line Detail'. The 'Comments' tab is active. Below the tabs is a table titled 'Authorization Header Comment List'. The table has two columns: '# Comment By' and 'Date/time'. A single row of data is visible, containing the text: 'Cost of item (tax included): \$49.99. Cost of shipping: \$5.00. Total authorization: \$54.99'. Below the table, there is a section for 'Selected Comment' with two input fields: 'Comment By:' and 'Date/time:'. At the bottom, there is another 'Selected Comment' field and a small icon.

2. For a client eligible for RCL, CFC's Community Transition Services (CTS) or WA Roads, a CCG may make a purchase for SES and be reimbursed (but never for DME). Authorized purchases can be made online or at a store like Home Depot (handheld shower) or Rite Aid (reacher).

Note Regarding Denials

A denial is not necessary if there is an item of DME 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..

DME PAN INFORMATION

- ❖ If DME is identified in CARE and the vendor is seeking coverage through insurance first, per policy, wait to see if item is covered by other sources before creating the social service authorization and sending the approval PAN.

*Do not send a Planned Action Notice (PAN) for any actions taken by HCA.

Items never covered by Medicare/Medicaid

Specialized equipment and supplies (non-medical items or SES) are items not covered by Medicare and never covered by Apple Health, but which may be covered by DSHS (such as reachers or handheld showers).

1. If the case worker determines the item is necessary for independent living, create an authorization in CARE and put the authorization in “Reviewing” status until it has been verified the client has received the equipment/item(s).
No denial is necessary for items never covered by Medicaid (This includes a Medicare “patient responsibility” denial).
2. Document the item being purchased in the Comments section of the authorization.
3. After verifying receipt of the item(s) by the client, update the status to Approved.
 - a. The vendor is not able to claim until the status is Approved, so it is important to do this in a timely manner.

Clients not covered by Medicare/ Medicaid

If the client has neither Medicare nor Medicaid and the item is needed for independent living (this includes clients on CHORE, enrolled in the program for non-citizens, or for DDA clients on the Individual and Family Services state program):

1. If the case worker determines the item is necessary for independent living, create an authorization in CARE and put the authorization in “Reviewing” status until it has been verified the client has received the equipment/item(s). No denial is necessary if the client is not covered by Medicare/ Medicaid.
2. Document the item being purchased in the Comments section.
3. After verifying receipt of the item(s) by the client, update the status to Approved. The vendor is not able to claim until the status is Approved, so it is important to do this in a timely manner.

Remember:

- A Medicaid denial is only necessary if the item is likely to be covered and the client is on Medicaid.
- A denial is not required if the client is not on Medicaid.
- A denial is not required if the item is never covered.

INCONTINENCE SUPPLIES FOR CLIENTS ON HOSPICE

For Medicaid clients on hospice when the necessary supplies are not a covered item, requests for things such as briefs go to Nancy Hite, Occupational Nurse Consultant at HCA, for review. She reviews and approves or denies coverage based on the following:

1. If the client had been getting adult incontinence briefs prior to the hospice election, most of the time these are approved (depending on the circumstances).
2. If the client has a medical condition that is related to the incontinence and the Hospice diagnosis, such as bladder cancer, or new onset altered mental status & bedbound, Hospice is responsible.
3. If the client is residing in a nursing home, hospice is not responsible; the nursing home is responsible. More than likely the client had been getting adult incontinence briefs before Hospice was elected.
4. If the client is in an adult family home and had been getting adult incontinence briefs prior to Hospice, it depends on the Hospice diagnosis if HCA would cover or Hospice.

NURSING FACILITY DISCHARGES & DME

For a client discharging from a nursing facility or other institutional setting:

1. Equipment needs should be evaluated early in the discharge planning process to allow sufficient time to get necessary equipment in place prior to discharge.
2. Case workers should coordinate with nursing facility discharge planners to get all medically necessary equipment through the client's medical benefit whenever possible.
3. The NFCM should follow local guidance regarding the timing of the case transferring. Some AAAs or residential offices may prefer that all equipment be delivered prior to transfer. Others may want the case sooner than that.

Did you know?

Medicaid will purchase the items below, when medically necessary, while the individual is in the nursing facility for the residents' use in the facility. The equipment belongs to the client and can be purchased even if the client has Medicare coverage. The client takes it with them when they discharge (per [WAC 182.543.5700](#)):

- One manual or power-drive wheelchair
- Speech generating devices
- Specialty beds (for example, a low airloss mattress. A heavy-duty bariatric bed is not a specialty bed)

FAQS

Q: Can I use Residential Care Discharge Allowance (RCDA), Community Transition Services (CTS), WA Roads or Residential Allowance Request (RAR) funds to purchase non-covered items such as toilet seat risers and grab bars?

A: Yes, after exhausting other benefits first:

- **HCS: CTS funds can be used in conjunction with other benefits and resources available. DME blanket codes are available using the Discharge Resource and WA Roads RACs.**
- **DDA: for RAR, the supported living provider can purchase the items and be reimbursed.**

Q. How do we pay for DME for Fast Track clients who are not yet approved for Medicaid?

A: Clients who are on COPES Fast Track have access to all of the COPES services. Since ProviderOne will not show that they are enrolled in Medicaid, the system will not look for a denial.

Authorizations & Service Codes

Remember as you go through this process, all equipment, supplies, or assistive devices related to a client's ADLs/IADLs should be reflected in the Care Plan, regardless of payor source. If the case manager is aware of a need or want, it should be included in the Care Plan even though DSHS may not be creating an authorization for it.

Authorizing DME

The screenshot displays the 'Line Detail' tab of a software interface. At the top, there are tabs for 'Header', 'Comments', and 'Line Detail'. Below the tabs, the 'Service Line' is set to 'New service line - SA875 - DME: Bathroom and toileting'. A link for 'P1 Common Errors' is visible. Below this, there are several sub-tabs: 'Line Data', 'Unresolved Errors', 'Resolved Errors', 'Comment History', 'Decrementing', 'Responsibility', and 'Line Data Audit Log'. The 'Line Data' sub-tab is active, showing a link for 'DME: Bathroom and toileting Appendix'. The form fields include: 'Service Code' (SA875), 'Service Name' (DME: Bathroom and toileting), 'Start' (00/00/0000), 'End' (00/00/0000), and 'Place of Service' (dropdown). Below these are fields for '# of Units' (0), 'Unit Type' (dropdown), 'Rate' (0.00), 'Total' (dropdown), 'Business Status' (dropdown menu), and 'Reason Code' (dropdown). The 'Business Status' dropdown menu is open, showing 'Approved' and 'Reviewing' options, with 'Reviewing' selected.

Case workers will select the Business Status “Reviewing” when authorizing DME. This allows the case worker to enter the authorization for the provider to view.

Case workers will select the Business Status “Approved” after verification that the client has received the item. This allows the vendor to claim in P1.

Authorizing DME

Header **Comments** Line Detail

Service Line: [P1 Common Errors](#)

New service line - SA875 - DME: Bathroom and toileting

Line Data **Unresolved Errors** Resolved Errors Comment History Decrementing Responsibility Line Data Audit Log

[DME: Bathroom and toileting Appendix](#)

Service Code: SA875 Service Name: DME: Bathroom and toileting Start: 00/00/0000 End: 00/00/0000 Place of Service:

of Units: 0 Unit Type: Rate: 0.00 Total: Business Status: Reviewing Reason Code:

Approved
Reviewing

Case workers must list the specific item(s) being purchased in the Comment box of the authorization.

Billers and providers

ProviderOne

Forms & publications

News

Contact Us

Provider billing
resources

Provider billing guides and fee schedules

For blanket codes, each code has a corresponding list of detailed HCPCS codes (HCPCS is the code the vendor must use when they bill; case workers do not need to know these codes).

Fee schedules are posted on [HCA's Billing Guide and Fee Schedule site](#). (Remember: Authorizations will pay at the Medicaid state rate regardless of the payer source.)

You can see the comprehensive list of detailed codes in a spreadsheet linked to the [DME Social Services Supplemental](#) (for your information only; staff do NOT need to know the detailed codes).

Durable medical equipment (DME)

Billing guides

- [October 1, 2017 - present](#)
- [July 1, 2017 - September 30, 2017](#)
- [January 1, 2017 - June 30, 2017](#)
- [October 1, 2016 - December 31, 2016](#)
- [View all DME billing guides](#)

Fee schedules

Other DME

- [January 1, 2017 - Present](#) (Published December 28, 2016)
- [April 1, 2016 - December 31, 2016](#) (Published March 14, 2016)
- [July 1, 2015 - March 31, 2016](#) (Updated January 28, 2016)
- [View all Other DME fee schedules](#)

Standard wheelchairs and accessories

- [April 1, 2016 - Present](#) (Published March 11, 2016)
- [July 1, 2015 - March 31, 2016](#) (Updated June 23, 2016)
- [View all Standard Wheelchairs fee schedule](#)

Additional materials

- [Social services supplement](#) (Updated January 1, 2017)

BLANKET CODES AND HCPCS CODES

- In most cases, the case worker only needs to know the blanket code [listed in the Social Service (SS) Supplemental guide as “Super Group”]. There are some specific codes that may need to be authorized.
- The vendor must bill using the specific HCPCS code (listed in as the Procedure/Service Code in the SS Supplemental guide).
- For example, to authorize a walker, the case worker authorizes **SA880**. Depending on the type of walker dispensed, the vendor will claim using one of the HCPCS codes included in the authorized blanket code.

Social Services Blanket Code to Procedure/Service Code

01/01/2017

Group Description	Super Group	Proc/Svc Code	Proc Short Desc	Proc Frm Dt	Proc To Dt
Mobility Aids and supplies	SA880	E0113	Crutch underarm each wood	1/1/1964	12/31/2999
Mobility Aids and supplies	SA880	E0118	Crutch substitute	1/1/1964	12/31/2999
Mobility Aids and supplies	SA880	E0130	Walker rigid adjust/fixed ht	1/1/1964	12/31/2999
Mobility Aids and supplies	SA880	E0135	Walker folding adjust/fixed	1/1/1964	12/31/2999
Mobility Aids and supplies	SA880	E0140	Walker w trunk support	1/1/1964	12/31/2999
Mobility Aids and supplies	SA880	E0143	Walker folding wheeled w/o s	1/1/1964	12/31/2999

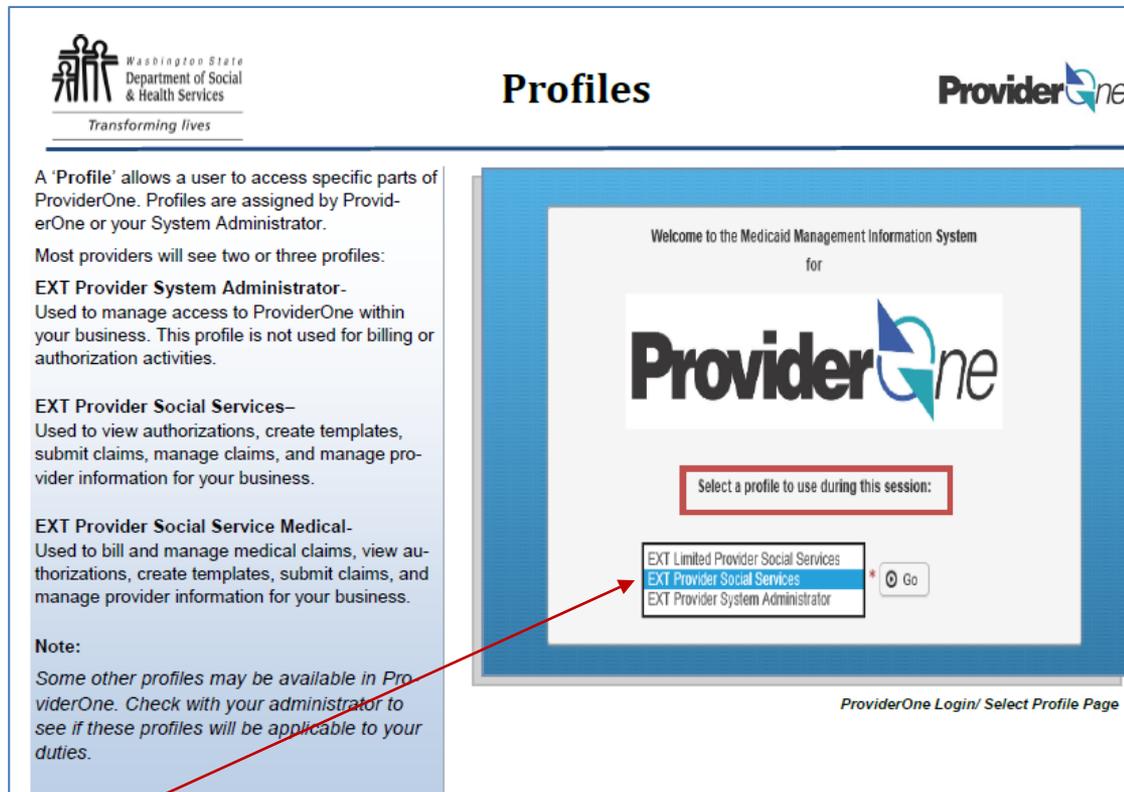
CM authorizes blanket code

Vendor claims using the detailed code

BILLING SOCIAL SERVICES IN P1

❖ Vendors:

- For HCA claims, you log in through your Medical profile.
- To claim a social services authorization you must be logged into your social services profile.



The screenshot shows the ProviderOne login interface. At the top left is the Washington State Department of Social & Health Services logo with the tagline "Transforming lives". The page title is "Profiles" and the ProviderOne logo is in the top right. The main content area is titled "Welcome to the Medicaid Management Information System for" and features the ProviderOne logo. Below the logo is a red-bordered box with the text "Select a profile to use during this session:". A dropdown menu is open, showing three options: "EXT Limited Provider Social Services", "EXT Provider Social Services" (which is highlighted in blue), and "EXT Provider System Administrator". A "Go" button is to the right of the dropdown. A red arrow points from the text "EXT Provider Social Services" in the list to the corresponding text in the explanatory text on the left. At the bottom right of the screenshot, it says "ProviderOne Login/ Select Profile Page".

Profiles

Washington State Department of Social & Health Services
Transforming lives

A 'Profile' allows a user to access specific parts of ProviderOne. Profiles are assigned by ProviderOne or your System Administrator.

Most providers will see two or three profiles:

EXT Provider System Administrator-
Used to manage access to ProviderOne within your business. This profile is not used for billing or authorization activities.

EXT Provider Social Services-
Used to view authorizations, create templates, submit claims, manage claims, and manage provider information for your business.

EXT Provider Social Service Medical-
Used to bill and manage medical claims, view authorizations, create templates, submit claims, and manage provider information for your business.

Note:
Some other profiles may be available in ProviderOne. Check with your administrator to see if these profiles will be applicable to your duties.

Welcome to the Medicaid Management Information System for

ProviderOne

Select a profile to use during this session:

- EXT Limited Provider Social Services
- EXT Provider Social Services**
- EXT Provider System Administrator

Go

ProviderOne Login/ Select Profile Page

For more information on billing social services is available [here](#).

EQUIPMENT REPAIR

- ❖ Medicare and/or Apple Health will sometimes cover for the repair of equipment when certain criteria are met with a prior authorization. Most items can be repaired.
- ❖ If an individual has equipment that needs to be repaired, the client should contact the DME vendor where the equipment was originally purchased (with the assistance of the case worker or physician's office).
- ❖ If returning to the vendor where the original purchase was made is not an option, a repair can be pursued from another DME vendor with a CPA.
- ❖ If the cost of the repair exceeds the cost of replacement, Apple Health may authorize replacement in lieu of repair.
- ❖ Authorize repair using K0739
 - Time and travel spent diagnosing repair issues are not compensated [see [WAC 182-543-9000\(8\)](#)].

My Client Needs DME: The Process

- ❖ Do not create any social service authorizations until all other available funding sources have been accessed.
- ❖ Remember: social services authorizations are not to be used to supplement Medicare or Apple Health rates.

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.
- Authorization criteria may vary for each MCO and may be slightly different than HCA's.
- Each managed care plan has its own network of contracted vendors.
- **All MCOs cover the same benefits (which mimic HCA's coverage), but it is not required they cover the same brands.**
- The contracted DME vendor should work directly with the MCO to obtain the necessary, 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, the case worker should not create an authorization for covered DME in ProviderOne.
- 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 services authorization being created.
- MCOs must cover gloves for IPs.

MANAGED CARE

If the individual is covered by a managed care organization such as:

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

The client or physician should contact the plan directly for program benefits.

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.

FAQS

Q: In the flow chart, it is indicated that the clients gets the prescription from their doctor and provides it to the DME vendor. Can't the vendor just get the prescription for the client?

A: Vendors are frequently hesitant to go directly to a physician to get a prescription because that can be viewed as “soliciting”, which they cannot do. A case worker or family member can assist the client, as necessary, to get the needed prescription. Some DME vendors will assist with this process.

DELIVERY AND SHIPPING

It is expected for equipment to be delivered following authorization. The provider bills after delivery. Many items require a date of delivery and serial number to be entered prior to being able to bill.

Shipping is included in the DME rate. There should be no additional charge for shipping per [WAC 182-543-9000\(8\)\(b\)\(d\)](#).

Private Insurance/ Medicare/Medicaid

Some items may require:

- Prior Authorization (PA)
- Expedited Prior Authorization (EPA)
- Limitation Extension (LE)
- Exception to Rule (ETR)

AUTHORIZATIONS

- ❖ The client must first coordinate with their health care provider to acquire the needed item or service through Medicare, private insurance, Apple Health or other available benefit.
- ❖ Per their Core Provider Agreement (CPA), DME vendors must exhaust other coverage before submitting a request for payment under a social services authorization.
- ❖ 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 medical benefit plan.
- ❖ For more information see the [ProviderOne DME Provider Billing Guide](#).

AUTHORIZATIONS

- ❖ For **covered items**, a prior authorization or limit extension must be requested by the DME vendor and denied by HCA before a social service authorization is pursued*.
- ❖ For **typically not covered items**, an exception to rule (ETR) must be requested by the DME vendor and denied by HCA before a social service authorization is pursued (with the exception of bathroom equipment that does not meet ETR criteria).
- ❖ Items that are **specialized equipment and supplies** (SES) do not require a denial from HCA before creating a social service authorization because they are never covered by a medical benefit.

*It is not required to pursue an administrative hearing following a denial to ensure DSHS is the payer of last resort. Administrative hearings should be limited to cases where it is believed the client meets exceptional criteria and was denied coverage of the item.

Medically Necessary ([HCA WAC 182-500-0070](#))

"Medically necessary" is a term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service.

EXCEPTION TO RULE (ETR)

❖ [HCA's WAC](#), which lists Medicaid non-covered items, includes items that may be covered under specific circumstances through an HCA exception to rule (ETR) process

❖ The DME vendor should be knowledgeable about this process.

❖ The client's medical provider should provide any clinical information documenting why the item is medically necessary.

Remember this slide?

❖ Only items listed in WAC as non-covered go through the ETR process.

Understanding Policy

❖ Among the list of items that are not covered by Medicaid per HCA [WAC 182-543-6000](#), there are two types that AL TSA/DDA may cover:

a) Specific **durable medical equipment** (DME) and supplies (e.g. transfer benches, bath equipment including grab bars, shower benches and commodes, etc.). WAC lists these items as "never covered" however, many of these items **may be** covered by a Medicaid benefit if the client meets exceptional criteria (via an ETR granting an exception to this rule).

b) **Non-medical equipment and supplies** (e.g. reachers, sock aids, handheld shower). We will refer to these items as specialized equipment and supplies (SES). These are considered "excluded" items because they are never covered by AH.

Prior Authorization:

- ❖ Under [WAC 182-543-7100](#), HCA requires providers to obtain PA for certain **covered** items and services before delivering that item or service to the client. There are certain criteria the vendor must follow (detailed in the [DME Billing Guide](#)).
- ❖ HCA may consider requests for new durable medical equipment (DME) and related supplies that do not have assigned health care common procedure coding system (HCPCS) codes, and are not listed in the provider guide. These items require PA.
- ❖ HCA doesn't pay for the purchase, rental, or repair of medical equipment that duplicates equipment the client already owns or rents. If the provider believes the purchase, rental or repair of medical equipment is not duplicative, the provider must request PA following instructions in the [DME Billing Guide](#). If the item has been lost or stolen, this should be noted in the PA.

Expedited Prior Authorization (EPA):

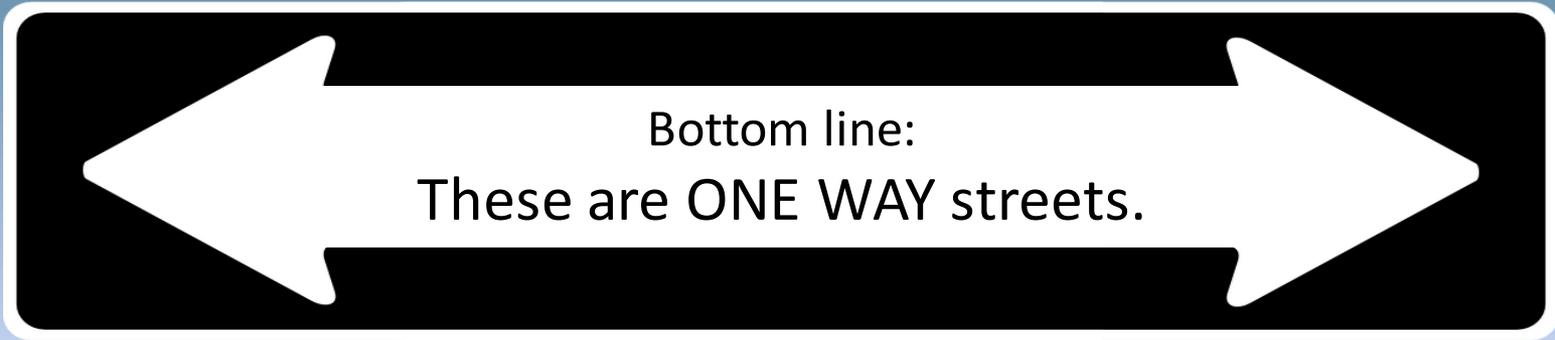
- ❖ HCA requires DME providers to create an authorization number for EPA for selected items. Providers must use this authorization number in order to bill (instructions are in the [DME Billing Guide](#)).
- ❖ The expedited prior authorization (EPA) process is designed to eliminate the need for written or telephone requests for prior authorization for **selected, covered DME procedure codes**. ([WAC 182-543-7300](#)).
- ❖ If a situation does not meet EPA criteria for the selected item, a written or telephone request is required.
- ❖ The DME vendors are responsible to know the criteria and follow the required process for items covered by the EPA process, the limits, etc. DSHS/AAA staff do not need to know the details of this process.

Limitation Extension (LE):

- ❖ Medicaid limits the amount, frequency, or duration of certain covered DME, and related supplies, and reimburses up to the stated limit without requiring prior authorization (PA).
- ❖ Certain covered items have limitations on quantity and frequency. These limits are designed to avoid the need for PA for items normally considered medically necessary and for **quantities sufficient for a thirty-day supply for one client**.
- ❖ The agency requires a provider to request PA for a LE in order to exceed the stated limits for nondurable medical equipment (DME), and medical supplies. ([WAC 182-543-7200](#)).
- ❖ If a client is running short on diabetic or incontinence supplies, an LE should be requested prior to a social services authorization being created.

HCA's Exception to Rule:

HCA evaluates a request for any DME, related supplies, and related services listed as **non-covered** under the provisions of [WAC 182-501-0160](#) (this is for the items listed as typically not covered only; an ETR is never submitted for items that are “never covered”). This might include blood pressure monitoring equipment, bathroom equipment (more detail to come) or custom compression garments.



PA, EPA and LE are the processes to obtain or extend limits on specific **covered items.**



ETR is the process to obtain items that are **typically not covered.**

PRIOR AUTHORIZATION OR ETR DENIALS

If the case worker has been told that an item was denied, the following steps should be followed:

1. The case worker should verify that all **available** payer sources have been exhausted, including checking in ProviderOne for Medicaid coverage.
2. The case worker should evaluate the need for the item to determine if the item is truly necessary.
3. DME coverage under all medical benefits is based on medical necessity. If an item was denied because medical necessity was not demonstrated, but the item is considered necessary **for independent living**, the case worker should document in a SER why the item is needed by the client.
 - a. Independent living means anyone living in a home and community setting which includes adult family homes and assisted living facilities.

PRIOR AUTHORIZATION OR ETR DENIALS

If the item was denied, (con't.):

4. The case worker creates an authorization in CARE putting the authorization in “Reviewing” status until it has been verified the client has received the equipment/item(s).
5. Once verification that the client has received the item, the case worker must change the authorization status to “Approved” in a timely manner. Not doing this in a timely manner will delay the vendors ability to claim.
6. **The *Authorization in Reviewing Status report* available on ADSA Reporting must be run routinely by offices to ensure timely update to status after delivery is verified(monthly at a minimum).**

PRIOR AUTHORIZATION: DENIAL

Remember:

- A DME vendor could be denied payment from a medical benefit provider because the vendor's medical claim was missing necessary information such as the prescribing medical personnel's National Provider Identifier (NPI) or the ICD-code, etc. The vendor must make the necessary corrections in order to receive payment through ProviderOne.
- This does not constitute denial of *benefit* to the client.
- Just because a denial occurred does not mean a social service authorization should be created.

PRIOR AUTHORIZATION: REJECTION

Remember:

- A DME vendor's prior authorization request could be **rejected** because the request was missing necessary information such as the prescribing medical personnel's National Provider Identifier (NPI) or the ICD-code, or the information is illegible, etc. The vendor must make the necessary corrections and resubmit the request in order to receive approval.
- A rejection does not constitute denial of *benefit* to the client.
- A rejection does not indicate a social service authorization should be created.

FAQS

Q:How should I deal with a vendor who refuses to get a denial first when I believe one is required?

A: Talk to the vendor. If the vendor feels like the client does not meet criteria for the item, a denial may not be necessary. If the individual is a dually eligible client (Medicare and Medicaid), the DME provider can add Medicare information to Box 30 to attest the client does not meet Medicare's criteria.

If you are not comfortable with what the vendor communicates regarding the situation, refer to HCA's Find a Provider list to find a different provider who will follow billing rules. You can also send an email to the DME@hca.wa.gov mailbox documenting the issue.

Q: If the client needs to find a new vendor, can he/she ask for the prescription back?

A: Yes, the client can request to have it returned or transferred. The prescription belongs to the client.

FOR IMMEDIATE NEED:

When there is an immediate need for the equipment due to a nursing facility discharge or for an in-home client who needs an item for their safety the vendor must:

1. Request a prior authorization with “Expedite for d/c” or “Home client: safety issues” in the comments section of the request form; and
2. Email DME@hca.wa.gov and include in the subject line “Expedite for d/c” or “Home client: safety issues”.
3. Use of “Home client: safety issues” will be monitored and if it is overused for situations that are not needed for the immediate safety of our clients, the process is subject to change.
4. The vendor should include in the email the client’s P1 ID and the authorization number.

FAQS

Q. What if an upgrade is medically necessary?

A: The vendor must explain why the upgrade is necessary in the PA process. The medical documentation must also support why the item is medically necessary.

Q. What if an upgrade is not medically necessary but the client prefers the upgrade and will pay privately for it? Can financial use the amount paid by the client as a participation adjustment?

A: No, because the upgrade was not medically necessary.

Q: Does P1 allow for a case worker to authorize the rental of DME? If so, what is the process?

A: The process for renting is the same as for purchasing. The vendor will use a different modifier. For nursing facility discharges, use the expedited process. Some items will be dispensed as a rental; typically after 12 months the rental item becomes the property of the client.

FAQS

Q: I have heard that Medicare will only pay for a 4 wheeled walker but not for the brakes or seat that my client needs on the walker. How is it paid for? Is this considered “up selling” to supplement the Medicare reimbursement rate?

A: If Medicare denies additional elements to the standard walker the vendor can submit a prior authorization or ETR to HCA along with the Medicare denial. If Medicaid denies the prior authorization or ETR, follow the process provided in today’s presentation. Purchasing additional parts for standard equipment, when necessary, is not considered supplementing the rate.

Q: My 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.

A: If the physician prescribed a 4 wheel walker then the vendor needs to bill primary payers for a 4 wheel walker. If the physician prescribed a 2 wheel walker and the client is requesting 4 wheels, DSHS cannot pay the difference.

FAQS

Q: How long does it take HCA to process an ETR?

A: HCA tries to look at ETR requests as they are submitted. The goal is within one business day of receipt of the ETR.

Q: Can DME vendors bill for the time it takes them to submit an ETR?

A: No.

Q: Do non-medical items require a prescription?

A: A prescription is not required for billing. The case worker should submit supporting documentation to the client's electronic case record (ECR). Claiming for social services authorizations such as SES does not require any additional detail codes, diagnosis codes, prescriptions, doctor info, Prior Authorization/Exception To Rule/Limit Extensions, etc. The vendor claims through the social services portal in ProviderOne, not the medical portal.

HOME MODIFICATIONS: HCS

Home modifications are not durable medical equipment and are never covered through Apple Health Medicaid. If the purpose is to increase or maintain independent living in the community, home modifications may be authorized by social services:

- If there will be any construction or modification to a dwelling, authorize using an environmental modification service code to a contracted environmental modification provider.
 - It is acceptable for the contractor to include items such as grab bars in the bid (no separate service code/approval is necessary for the grab bars, etc. when the bid is bundled).
- If no construction or modification is needed (no installation required), such as for a portable ramp, use a non-medical service code and a provider with the Specialized Equipment and Supplies contract with the correct taxonomy (very minimal securing using a few screws is not considered construction).

HOME ADAPTATIONS: DDA

Home adaptations are not durable medical equipment and are never covered through Apple Health Medicaid. If the purpose is to increase or maintain independent living in the community, home adaptations may be authorized by social services:

- If there will be any construction, modification or attachment to a dwelling, authorize using an environmental adaptation service code to a contracted environmental modification provider. This includes portable ramps.
 - It is acceptable for the contractor to include items such as grab bars in the bid (no separate service code/approval is necessary for the grab bars, etc. when the bid is bundled).

MOVING EQUIPMENT

Some equipment may be too complex for a contracted mover to disassemble and reassemble, such as a hospital bed. Unless the DME vendor where the item was originally purchased is willing to move the equipment, case workers should:

- **Authorize a contracted mover to move the equipment (for WA Roads use SA291. For RCL use SA297).**
- **Authorize a DME vendor to disassemble and reassemble the equipment (use SA626 to authorize payment for the disassembly/assembly of the equipment).**
- **It will require two separate authorizations.**

Bathroom Equipment

Bathroom equipment is included in HCA's "non-covered" WAC. However, when exceptional criteria are met, sometimes bathroom equipment is considered medically necessary and will be purchased through the client's Apple Health. Commonly requested items include, but are not limited to:

- Bath stools
- Shower chair
- Bed pan
- Raised toilet seat
- Shower/commode chair
- Bedside commode chair
- Bathtub wall rail (grab bars)
- Standard and heavy duty bath chairs
- Toilet rail (grab bars)
- Transfer bench for tub or toilet
- Urinal

Bathroom Equipment

Examples of **reasons** when a client's Apple Health benefit **MAY** cover bathroom equipment include when the client has a new, acute diagnosis such as:

- Recent hip fracture
- New amputation
- New spinal cord injury with paraplegia
- Degenerative Joint Disease (DJD) with new cerebrovascular accident (CVA or stroke)

Examples of **client conditions/issues** where the client's Apple Health benefit **will never cover** bathroom equipment include, but are not limited by:

- Chronic illness
- Fatigue
- Malaise
- Debility
- Deconditioning
- Osteoarthritis
- Obesity
- Increased age with no caregivers
- Prevention of out-of-home placement

Bathroom Equipment

- A service level agreement between ALTSA, DDA and HCA allows for an ALTSA or DDA approval from HQ to purchase bathroom equipment.
- This provides assurance to HCA and CMS that federal Medicaid rules continue to be met.

Bathroom Equipment

If it appears to the vendor or case manager that the client likely meets HCA's exceptional criteria, the vendor must submit an ETR to Apple Health (AH) Medicaid following all instructions in the DME Billing Guide:

1. If the ETR is approved, the client receives the item and the vendor claims as usual.
2. **If the ETR is denied by AH** and the case worker determines the item is necessary for independent living (and the need is documented on the equipment screen or appropriate ADL screen), create an authorization in CARE using blanket code SA875 and put the authorization in "Reviewing" status until it has been verified the client has received the equipment/item(s).
3. Document the item being purchased in the Comments section.
4. Once the case manager has verified receipt of the item, the authorization must be changed to "Approved" status.
5. When the provider claims in P1, the system will detect the denial of the AH ETR and pay the claim based on the social service authorization

Bathroom Equipment Process: DDA

If it is apparent to the vendor or case manager that the client does not meet HCA's exceptional criteria and the bathroom equipment is necessary for independent living, the DDA Case Resource Manager should follow the established DDA Prior Authorization process.

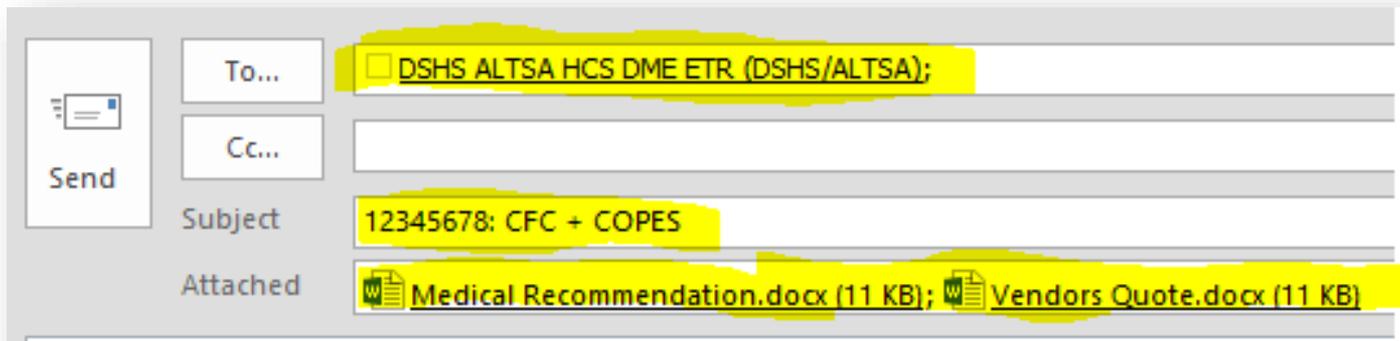
Bathroom Equipment: LTC

If it is apparent to the vendor or case manager that the client does not HCA's exceptional criteria and the bathroom equipment is necessary for independent living, the case manager:

1. Assesses and documents the client's need on the equipment screen or specific ADL/IADL screen (Toileting or Bathing).
2. Obtains recommendation from the client's health care professional (this does not need to be on prescription; a recommendation on professional letterhead is sufficient; make an electronic copy to submit with the ETR).
3. Requests quote(s) from DME provider.
4. DME provider submits to the case manager:
 - a. The Manufacturer's Suggested Retail Price (MSRP); **or**
 - b. The vendors wholesale cost of the item (what they pay for the item)
 - ✓ The vendor must indicate which they have included.
 - ✓ The Medicaid rate allowed for the item is 80% of the MSRP or 125% of the wholesale cost paid by the vendor, plus sales tax.

LTC Bathroom Equipment con't

5. The local ETR is processed following local policy.
6. If approved at the local level, the HCS/AAA case manager submits the following to the HCS DME ETR mailbox at dmeetr@dshs.wa.gov :
 - a. Supporting recommendation from the individual's health care provider
 - b. The DME vendor's quote cost or MSRP calculation plus sales tax.
 - c. Include in the email's subject line:
 - i. The individual's ACES ID; AND
 - ii. The program that will be used to authorize the bathroom equipment (e.g., 0123456: RCL or 00987654: COPEs).
 - iii. AAAs outside of the DSHS firewall must use secure email to submit supporting documentation to the HCS DME ETR committee.



LTC Bathroom Equipment con't

8. An AL TSA representative will review the request submitted in CARE.
9. If CARE request is approved, case manager creates authorization of approved equipment using DME blanket code SA875, following all DME instructions, including putting the authorization into “Reviewing” status.
10. Upon confirmation that the individual has received the goods, the case worker will update the authorization status to “Approved” and the DME provider will be able to claim.
11. Case Manager should submit a Social Services Packet Cover Sheet to DMS with the final invoice from the vendor and medical recommendation paperwork attached.

Bathroom Equipment Calculation

Medicaid rates allow either:

- 80% of Manufacturer's Suggested Retail Price (MSRP) plus tax
- OR
- 125% of vendor's purchase price plus tax

NOTE: If the Vendor only provides a quote of what they typically charge for the item, ask them for one of the above. The ETR will not be processed with only a quote of the vendor's selling price.

What's The Difference: Quote, vendor invoice or MSRP?

- Quote: the price the vendor is *charging* for the item
- Vendor invoice: the cost the vendor *paid* for the item.
- MSRP: the Manufacturer's Suggested Retail Price



Example of MSRP Rate Sheet

You may see the MSRP submitted like this:

Material	Desc	UOM	MSRP
13008	Over Bed Table,Tilt,1/cs	CV	170.3
13023	Patient Lift,New Style,1/cs	CV	1287
13067	Overbed Table,SilverVein,Dlx.,1/cs	CV	153.37
13244	Bariatric Lift,Elect,Homecare Style,1/cs	CV	3887
13609	Bed Size Patient Alarm w/Reset,1/ea	EA	247.52
14003	APP Pad Only, 1/ea, RTL	EA	42.87
14886	W/C Cushion,3in Gel/Foam,18"x16"x3",1/cs	CV	75.4
14893	PremGuardGel/FoamOverlay34x76x3.5in,1/cs	CV	311.97
15006	Mattress,80in Inner-Spring,1/ea	EA	290.4
15007	Mattress, 80" Fiber-Core, 1/ea	EA	290.4
15064	Bed Assist Handle,1/ea, RTL	EA	104
15305	Head Frame for 15300,1/cs	CV	1208.59
		CV	246.97

LIFT CHAIRS

Note: Lift chairs can only be purchased from Durable Medical Equipment (DME) vendors.

- ❖ DME vendors bill separately for the two components which make up a lift chair. Those components are:
 1. The lift mechanism/motor portion; and
 2. The furniture portion.
- ❖ A prescription or recommendation from a medical professional (physician or physician and therapist) is required prior to authorization.
- ❖ The Mechanism/motor portion:
 - There is very specific criteria that must be met for Medicare to cover the lift/motor portion. Criteria includes:
 - *Severe arthritis of the hip or knee, or severe neuromuscular disease, or be part of a course of treatment prescribed by a physician, or the client must be completely incapable of standing from a regular chair in their home and once standing the client must have the ability to ambulate.
 - Medicare will not cover this item if the client has a wheelchair, scooter or power wheelchair on file.

LIFT CHAIRS: LIFT MECHANISM

- 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 CHAIRS: FURNITURE PORTION

❖ Furniture portion:

- The furniture portion is never covered by Medicare.
- 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 CHAIRS PROCESS

The authorization process is as follows for client enrolled in Medicare and it is apparent the client meets Medicare's medically necessary criteria:

1. Per Medicare policy, the chair must be delivered prior to billing. The process of submitting a quote to the case manager detailed in this presentation may be used as assurance that a social service authorization will be created if the lift portion is denied by Medicare.
2. The vendor submits claim to Medicare for the lift mechanism/motor.
3. If Medicare pays for the lift mechanism/motor:
 - ❖ Create an authorization using SA419 (Lift Chairs- Furniture portion only) for the balance remaining on the price of lift chair. The balance remaining may include a portion of the lift mechanism – sometimes Medicare only covers 80% of the cost. The maximum amount allowed under this service code is \$1800.00. There is no exception to this limit.
4. If Medicare denies the claim for the lift mechanism: since the client has already received the lift chair, complete the authorizations in Approved Status (SA879 and SA419):
 - ❖ SA879 (in “Approved” status) for the lift mechanism/motor portion; and
 - ❖ SA419 (in “Approved” status) for the furniture portion of the basic lift chair

LIFT CHAIRS PROCESS

The authorization process is as follows for client enrolled in Medicare and it is apparent 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 a social services authorization using:
 - ❖ SA879 (in “Reviewing” status) for the lift mechanism/motor portion; and
 - ❖ SA419 (in “Approved” status) for the furniture portion of the basic lift chair (use an end date beyond the anticipated delivery as this is a one-time payment).
2. After the case manager has confirmed with the client/representative that the lift chair has been delivered, the status of SA879 need to be changed to “Approved” to allow the vendor to claim payment.

LIFT CHAIRS 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 “Approved” status) for the furniture portion of the basic lift chair (use an end date beyond the anticipated delivery as this is a one-time payment).
2. After the case manager has confirmed with the client/representative that the lift chair has been delivered, the status of SA879 needs to be changed to “Approved” to allow the vendor to claim payment.
3. Client responsibility/participation applies.
4. Items purchased under this authorization must be of direct medical and remedial benefit to the client.

FAQS

Q:What happens if I create a social service authorization but the rate I use is higher than the Medicaid reimbursement rate?

A: The provider will be paid at the Medicaid reimbursement rate or the authorized rate, whichever is **lower**. The social service authorization should be created using the estimated total cost. If the vendor's cost exceeds the reimbursement rate, the vendor has a process for submitting requests to HCA to have the rate increased.

Q: How about if the reimbursement rate is too low and the vendor won't supply the equipment because the actual cost of the item is more than the reimbursement rate?

A: The vendor can request a rate increase using the email address provided earlier: DME@hca.wa.gov

FAQS

Q: Can hearing aids or eye glasses be covered through a social service authorization?

A: For DDA: hearing aids only. Use blanket code SA893. For those under 21, it is part of the client's Apple Health benefit. Eyeglasses are not covered.

For HCS: COPES and RCL do not cover hearing aids or glasses. In New Freedom, a client can use their budget to purchase these items. Hearing aids and eyeglasses cannot be purchased using the \$500 spending limit for a client enrolled in CFC.

If a client wonders if their client responsibility could be reduced due to the purchase of hearing aids, they should follow up with their HCS financial worker.

FAQS

Q: If a specific DME item has been denied many, many times in the past, does the vendor still need to get a denial for the next client on the same item?

A: Yes. This is because the prior authorization and ETR are specific to an individual's diagnosis and other criteria. If the same client has received a denial for the same item in the same benefit year, no denial is necessary.

Q: What about blood pressure monitors? Are they covered, not typically covered or never covered items?

A: Blood pressure monitors are “typically not covered”. The vendor should request an ETR through HCA when a blood pressure monitor is medically necessary for a client. Misc. Blanket code SA879 should be used to authorize a blood pressure monitor if the ETR to HCA/MCO was denied and it is necessary to support independent living.

FAQS

Q: The vendor has asked to be paid to submit a bid as it requires a home visit. Is this acceptable?

A: No; the vendor is prohibited from doing this.

Q: When authorizing DME for multiple items do we do a separate line for each item to be paid for? Or do we do a lump sum payment?

A: You should authorize using a lump sum for the same blanket service code (such as purchasing several items of bathroom equipment using SA875) but the vendor will claim each item separately.

Q: Can a vendor require a Medicaid enrollee or his/her family to have a credit card on file prior to supplying an item?

A: This may be a common practice for rentals for non-Medicaid enrollees, but this is prohibited for individuals with Medicaid coverage. Make sure the vendor knows the client is a Medicaid enrollee or applicant; no credit card should be required.

FAQS

Q: If I communicate with a DME vendor via email, do I need to use encrypted email? If so, how do I do that?

A: Yes, all client specific communication with contracted providers, including DME vendors, must use the state [Secure Email System](#).

The vendor must also communicate to you using encrypted email anytime there is client information included. If staff receive emails with client's personally identifying information, they must remind the vendor to use the secure email system. This is included in their agreement.

DME Billing Guide

Diabetes Education Program

Durable medical equipment (DME)

Billing guides

- [October 1, 2017 - present](#)
- [July 1, 2017 - September 30, 2017](#)
- [January 1, 2017 - June 30, 2017](#)
- [October 1, 2016 - December 31, 2016](#)
- [View all DME billing guides](#)

Fee schedules

Other DME

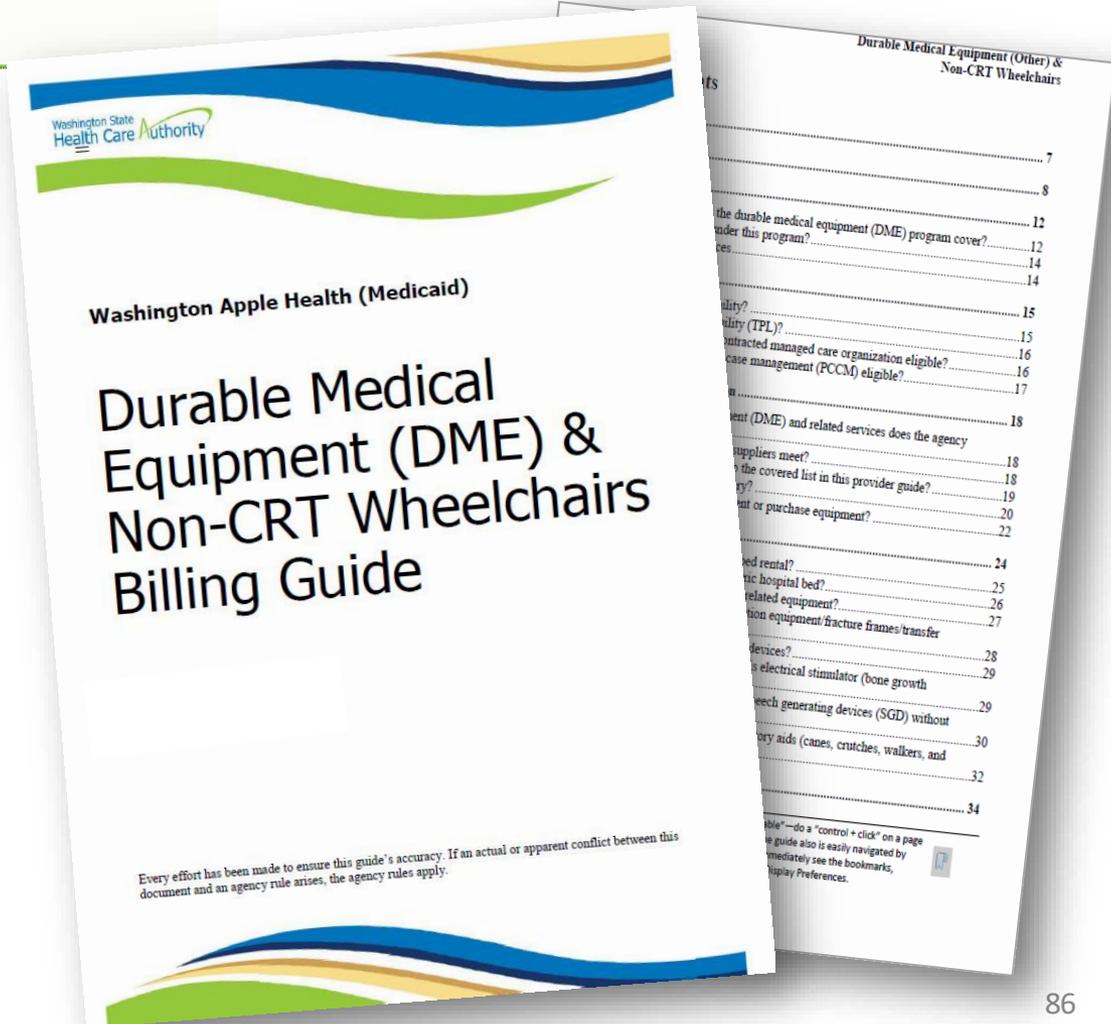
- [January 1, 2017 - Present](#) (Published December 28, 2016)
- [April 1, 2016 - December 31, 2016](#) (Published March 14, 2016)
- [July 1, 2015 - March 31, 2016](#) (Updated January 28, 2016)
- [View all Other DME fee schedules](#)

Standard wheelchairs and accessories

- [April 1, 2016 - Present](#) (Published March 11, 2016)
- [July 1, 2015 - March 31, 2016](#) (Updated June 23, 2016)
- [View all Standard Wheelchairs fee schedule](#)

Additional materials

- [Social services supplement](#) (Updated January 1, 2017)



Don't forget....

At any point in this process, a DME provider may submit a quote to a case worker with documentation that a physician has prescribed an item. Upon receipt of the quote:

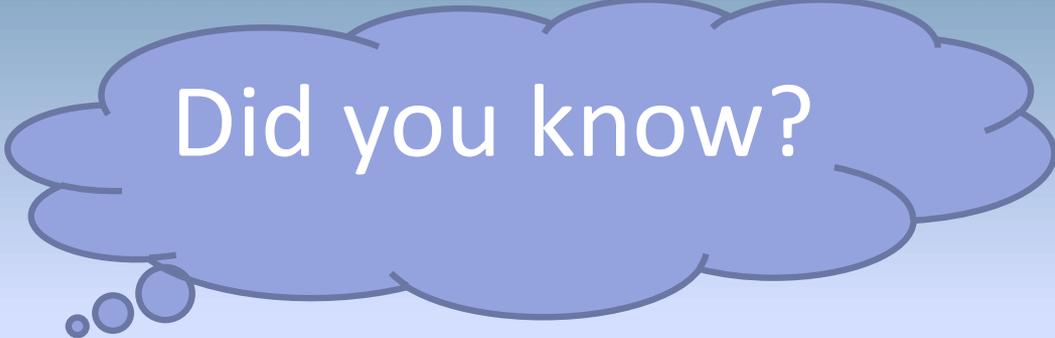
- The case worker can sign and return the quote to the provider as an indication they are in agreement with the physician that, regardless of whether the item is deemed medically necessary by Medicare or Medicaid, the item is necessary for independent living.
 - Signing the quote assures the DME provider that should private insurance, Medicare, or Medicaid deny the item, a social service authorization will be created.
- If signing the quote, the case worker should include the statement “***Not to exceed the Medicaid reimbursement rate***” with their signature.
 - Signing the quote does not indicate that DSHS agrees to pay the amount, only that a social services authorization will be created once all other payors have been exhausted and a final invoice has been received by the case worker.
 - The provider will be paid at the Medicaid reimbursement rate or the authorized rate, whichever is lower.

WHAT ARE SOME THINGS A CASE WORKER **SHOULD** **NOT DO** TO ASSIST WITH OBTAINING DME?

- ❖ Don't try to work around the system.
- ❖ Don't use your own credit card, the PCard, or any other card.
- ❖ Don't use the Fred Meyer, Shopko or other account.
- ❖ Don't use a CCG to make the purchase and be reimbursed.
- ❖ Don't put the equipment in someone else's name, including your own.
- ❖ Don't use an inaccurate code simply because it will "go through" with no issues.

Don't forget...

- The email response box has been provided to submit questions directly to the experts at HCA. **It is available to vendors and DSHS staff when you have questions:**
 - DME mailbox address: DME@HCA.WA.GOV
 - Suggested subject lines:
 - Expedite for D/C (for d/c within 1 week)
 - Home client: safety concerns
 - Rates Request (if the vendor says the rate doesn't cover the cost of the item).
 - When Medicare is primary payer, but client doesn't meet Medicare medically necessary criteria, enter "Doesn't meet Medicare's MN criteria"



Did you know?

Not all items will be denied!

We have spent a lot of time talking about denials. But the fact is many items WILL be covered appropriately through client's medical benefit whether it is private insurance, Medicare or Apple Health,

This means:

- Washington state will be in compliance with federal regulation.
- Case workers will not be creating as many social service authorizations because most of the equipment necessary for DSHS clients will meet the medical necessity requirement.

Resource Links

- [HCA's DME Website](#) (the final of this presentation will be posted here)
- [HCA's Find a Provider List](#)
- [WAC 182-500-0070 Medically Necessary](#)
- [ProviderOne DME Provider Rates and Billing Guide](#)
- [Medicare Supplier Directory](#)
- [Noridian](#) (Medicare's DME claims administrator for our jurisdiction; you can find a list of covered and non-covered items here.)

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