

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 12**

POLICY TITLE: PROCUREMENT OF DURABLE MEDICAL EQUIPMENT

POLICY STATEMENT:

Durable medical equipment (DME) determined to be medically necessary by a participating Health Plans' practitioner that is primarily and customarily used to serve a medical purpose, and is ordered through a participating durable medical equipment supplier, is covered according to the benefits stated in the Health Plan contract.

PURPOSE: For verification of medical necessity, monitoring of patient utilization, and assurance of quality medical equipment being provided to Health Plans' members.

PROCEDURE:

1. Request for DME is received by the Health Care Services nursing staff from patient, Health Plans' practitioner, facility, or referral practitioner.
2. Information regarding the nature of the durable medical equipment is taken, specifically the type of equipment.
3. If the equipment is routine, i.e.: hospital bed, wheelchair, walker, commode, etc., the caller is educated on DME providers in the Health Plans' network. The caller is told that an order from a Health Plans' practitioner or a practitioner treating the patient on an approved referral is needed in order to verify the medical necessity of the equipment.
4. The caller is then directed to channel request through DME provider with the practitioner orders.

Note: If equipment cannot be supplied through the Health Plans' network DME providers, the Health Care Services Case Manager will work with providers to make arrangements to obtain equipment. An authorization is entered into the computer system to indicate coverage if a non-plan provider is utilized. The Case Manager will negotiate fees.

5. Approval notifications may be given orally, electronic, or written. The notification for approvals will be communicated by the Health Care Services Staff to the Health Plans' subscriber and attending practitioner in the following manner:
 - a. For **pre-service of non-urgent care decisions**, the organization must give oral, written or electronic notification of the decision to practitioners and members within 15 calendar days of the request.

For non-urgent pre-service decisions, if the organization is unable to make a decision due to matters beyond the control of the organization, it may extend the decision time frame up to 15 calendar days. Within 15 calendar days of the pre-service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

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If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific information needed within 15 calendar days of the pre-service request. The written or electronic notice must describe the required information specifically. It must also specify the time period given to the member or to the member's authorized representative to provide the information. The member or the member's authorized representative must be given 45 days to provide the information. The decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension period, within which time a decision must be made by MAHP, begins on the date on which the member's response is received (without regard to whether all of the requested information is provided) or the end of the specified time period given to the member or the member's authorized representative to supply the information, whichever is earlier.

The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

- b. For **pre-service of urgent care decisions**, the organization must give oral, written, or electronic notification of the decision to practitioners and members within 72 hours of the request. If the organization is unable to make a decision due to lack of necessary information, it may extend the decision time frame once for up to 48 hours. The member or the member's authorized representative must be notified within 24 hours of the specific information needed.
- c. For **urgent concurrent review decisions** the organization must give oral, written, or electronic notification of the decision to practitioners and members within 24 hours of the request.
- d. For **post-service (retrospective review) decisions**, the organization must give oral, written or electronic notification of the decision to practitioners and members within 30 calendar days of the request.

For non-urgent post-service decisions, if the organization is unable to make a decision due to matters beyond the control of the organization, it may extend the decision time frame up to 15 calendar days. Within 30 calendar days of the post service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific

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information needed within 30 calendar days of the post service request. The written or electronic notice must describe the required information specifically. It must also specify the time period given to the member or the member's authorized representative to provide the information. The member or the member's authorized representative must be given at least 45 days to provide the information.

The decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension, within which a decision must be made by MAHP, begins on the date on which the member's response is received by MAHP (without regard to whether all of the requested information is provided) or the end of the specified time period given to the member or the member's authorized representative to supply the information, whichever is earlier.

The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

6. Denials are issued, documented, and communicated according the Health Care Services Policy #2 – Health Care Services Denial Policy & Policy # 2A – Health Choices Denial.
7. All DME requests for items over \$500 will be reviewed by the Case Manager for appropriateness and if approved, an auth is entered into the system. Health Choices is determined by each individual contract.
8. No authorization is required for Heated Humidifiers, C-Paps, Bi-Paps or Tens units.
9. The following items will require prior authorization to determine medical necessity even though they are under \$500.00; Vacuum erection devices, Diabetic shoes, Seat lift mechanisms, CPM machines & Apnea monitors.
10. The purchase of items over \$2000.00 is to be prior-approved by the Director or Manager of Health Care Services. If the durable medical equipment is specialized, research and information regarding the orders are to be given to the Director or Manager of Health Care Services for signature. Documentation is then made by the Prior Auth Case Manager and entered into the information system.-(Exception: See # 11)
11. "CMN (Certificate of Medical Necessity)" forms for DME ordered by Medical Associates Clinic practitioners are received from the DME provider by the designated Patient Services staff. Information to be provided on the form includes diagnosis, length of time equipment is needed, and reason equipment is needed. This information is retrieved on behalf of the practitioner and patient from the patient's medical record. The completed "Medical

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Necessity" forms are sent to the attending practitioner for review and signature. Forms are then returned to the DME dealer.

12. All other "Medical Necessity" forms for DME ordered by non-Medical Associates Health Plans' practitioners are forwarded directly to them for completion and returned to the DME provider.

13. Language to use for DME Prior Authorizations

- Contracted Providers: Will pay at Medicare allowable subject to member's contractual limitations and subscriber agreement.
- Non-contracted Providers: Will pay at usual, customary, and reasonable rate "UCR" subject to the member's contractual limitations and subscriber agreement.

14. Replacement of Oxygen Concentrator & Supplies

NOTE: Payment can be made for replacement of oxygen equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen or irreparably damaged.

- **Non-Medicare (Commercial HMO/CHP including Health Choices):** All oxygen equipment requested to be replaced needs a prior auth even if under \$500.00. The request must include the following for review:
 - Completed CMN (Certified Medical Necessity Form)
 - Documentation and explanation of why the equipment is needed:
 1. Chronic Hypoxia with the following conditions:
 - a. Diffuse interstitial lung disease
 - b. Chronic obstructive pulmonary disease
 - c. Cystic fibrosis
 - d. Bronchiectasis
 - e. Widespread pulmonary neoplasm
 - f. Pediatric bronchopulmonary dysplasia (BPD)
 - g. Pulmonary hypertension
 - h. Recurring congestive heart failure due to chronic cor pulmonale
 2. Acute Hypoxia with the following conditions:
 - a. Pneumonia
 - b. Bronchiolitis
 - c. Exacerbation of chronic obstructive pulmonary disease
 3. Diagnoses unrelated to hypoxia:
 - a. Cluster headaches
 - Equipment is malfunctioning or damaged. Explicitly stating what is wrong with the equipment.
- **Not Medically Necessary:**
 - When there is no documentation of hypoxia as described above with the exception of cluster headaches.

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- When used for the treatment of angina pectoris or dyspnea in the absence of documented associated hypoxia or cor pulmonale.
- The use of preset regulators used with portable oxygen systems.
- The equipment is functioning properly and is not damaged.

15. Maintenance and Servicing of Oxygen Equipment for MEDICARE ONLY

- Effective for oxygen equipment, other than stationary or portable gaseous or liquid oxygen equipment, furnished on or after July 1, 2010
- A maintenance and servicing fee of \$66 is paid every 6 months, either beginning: 1) 6 months after the 36th paid rental month; or 2) when the item is no longer covered under the supplier's or manufacturer's warranty (whichever is later).
- HCPCS that **apply** to this maintenance fee
 - E1390 – Oxygen concentrator, single delivery port
 - E1391 – Oxygen concentrator, dual delivery port
 - E1392 – Portable oxygen concentrator, rental
 - E0433 – Portable liquid oxygen system, rental
 - K0738 – Portable gaseous oxygen system, rental
- HCPCS that **do not** apply to this maintenance fee
 - E0424 – Stationary compressed gaseous oxygen system, rental
 - E3431 - Portable gaseous oxygen system, rental
 - E0434 – Portable liquid oxygen system, rental
 - E0439 – Stationary liquid oxygen system, rental

Attachment: Durable Medical Equipment Pre-Authorization Form
CMS MedLearn Matters (MM6792)

Judy Riniker, R.N.
Manager of Health Care Services/Quality Improvement

Date

Mary Leary, R.N.
Director of Health Care Services/Quality Improvement

Date

Original: 07/89	Revised: 10/95	Revised: 05/00	Revised: 03/06
Revised: 02/90	Revised: 05/96	Revised: 05/01	Revised: 03/07
Revised: 02/91	Revised: 05/97	Revised: 03/02	Revised: 06/07
Revised: 04/92	Revised: 03/98	Revised: 03/03	Revised: 12/07
Revised: 07/94	Revised: 02/99	Revised: 03/04	Revised: 03/09
Revised: 08/94	Revised: 02/00	Revised: 03/05	Revised: 05/09

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Revised: 02/10
Revised: 06/10
Revised: 10/10
Reviewed: 02/11
Revised: 01/12

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MEDICAL ASSOCIATES
HEALTH PLANS®

Durable Medical Prior Authorization Form

Date: _____

Patient name: _____
Member Number: _____
Date of Birth: _____
Patient Address: _____

Physician: _____
Patient Diagnosis & Code: _____

Medical Equipment Prescription with appropriate HCPC Codes: _____

Price: _____

****CHANGE AS OF 10/1/2009****

All DME requests need to have documentation from the providers' office sent to Health Care Services with this prior authorization. The request for coverage for DME cannot be reviewed unless the following documentation is included.

- Prior auth form completely filled out.
- Certificate of Medical Necessity (if applicable)
- Signed Dr.'s order
- Physicians notes from the medical record to support need for the DME equipment or notes that state the medical necessity.

Supplier's Name & Address: _____

For our **contracted providers**: Will pay at contractual allowable subject to member's contractual and/or Medicare limitations and subscriber agreement.

Date Approved: _____

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Signature: _____

Return to:

Health Care Services
Attention: Prior Authorization
Medical Associates Health Plans, Inc.
1605 Associates Drive Suite 101
Dubuque, Iowa 52002
Fax: (563) 585-1545 Telephone: (563)584-3275 or 1-800-325-7442