Prior Authorization Process for Non-Customized Wheelchairs

February 13, 2018

HUSKY HEALTH CONNECTICUT

Connecticut Department of Social Services

Making a Difference

Objectives

- To improve understanding of the HUSKY Health program's Prior Authorization (PA) process for non-customized wheelchairs
- Describe and use the Department of Social Services (DSS) Fee Schedule
- Outline documentation requirements
- Reduce the administrative burden associated with the PA process

Prior Authorization Overview

- All HUSKY Health members are eligible to receive healthcare goods or services from Connecticut Medical Assistance Program (CMAP) enrolled providers
- *Only CMAP enrolled providers will be reimbursed* for goods or services provided to HUSKY Health members
- All ordering, prescribing, or referring practitioners must be enrolled as either an ordering/prescribing/referring (OPR) or CMAP provider
- Determinations are made on a case-by-case person-centered clinical assessment of members and their clinical needs
- Payment is based on the member having active coverage, benefits, and policies in effect at the time of service
- All determinations are made on the basis of medical necessity and must be in compliance with the Definition of Medical Necessity, Connecticut General Statutes § 17b-259b(a)

Definition of Medical Necessity

- Section 17b-259b(a)
- “Medical Necessity” (or “Medically Necessary”) means those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate an individual’s medical condition; including mental illness, or its effects, in order to attain or maintain the individual’s achievable health and independent functioning provided such services are:

  (1) Consistent with generally-accepted standards of medical practice that are defined as standards based on:

  (A) Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community,

  (B) Recommendations of a physician-specialty society,

  (C) The views of physicians practicing in relevant clinical areas, and

  (D) Any other relevant factors;

Definition of Medical Necessity (cont.)

(2) Clinically appropriate in terms of type, frequency, timing, site, extent and duration, and considered effective for the individual's illness, injury or disease;

(3) Not primarily for the convenience of the individual, the individual's healthcare provider, or other healthcare providers;

(4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury, or disease; and

(5) Based on an assessment of the individual and his/her medical condition.

All final determinations of medical necessity must be based upon this statutory definition

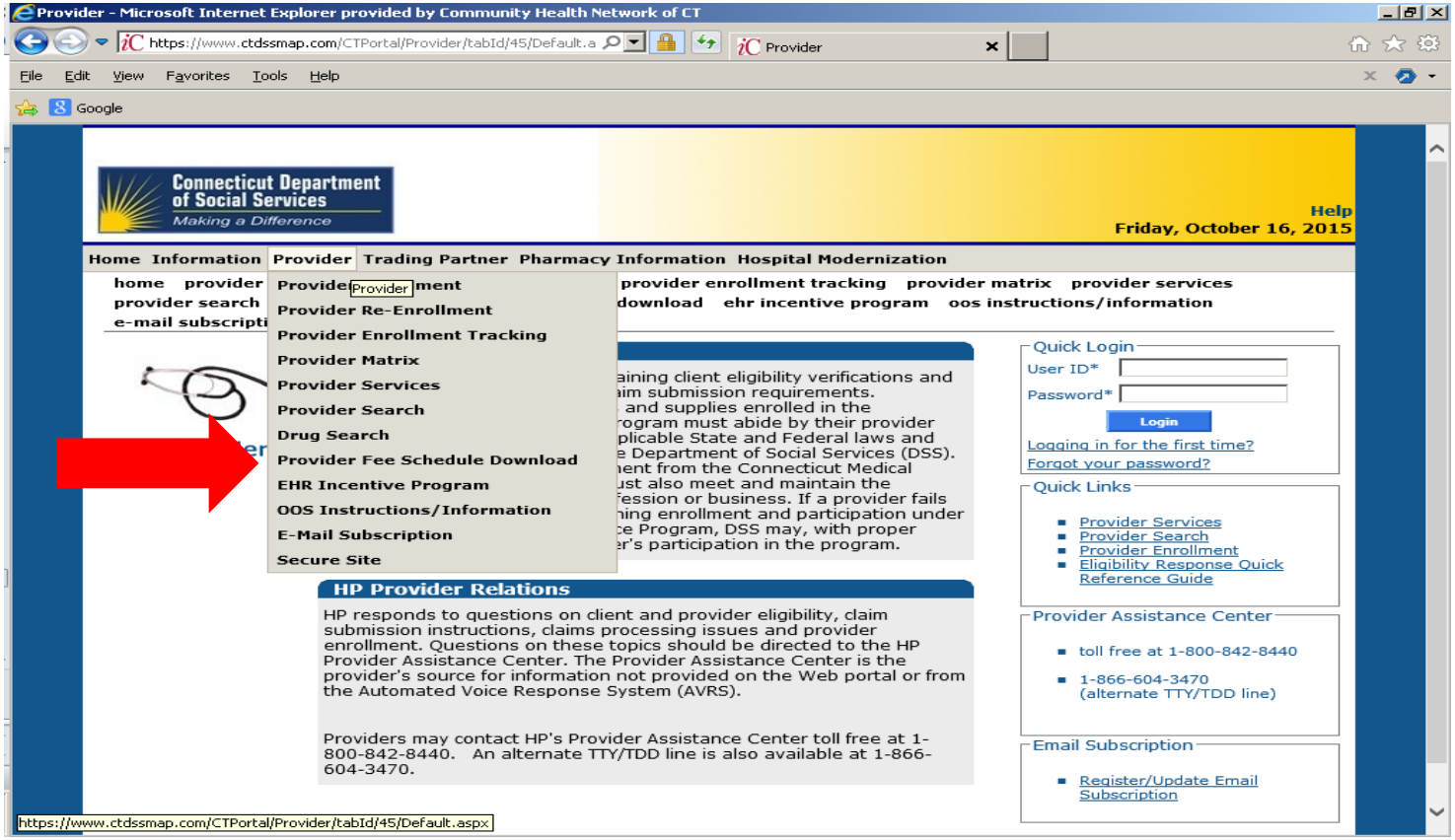
DSS Fee Schedule

Locating the DSS Fee Schedule

- Go to www.ctdssmap.com
- Click on ***"Provider"***

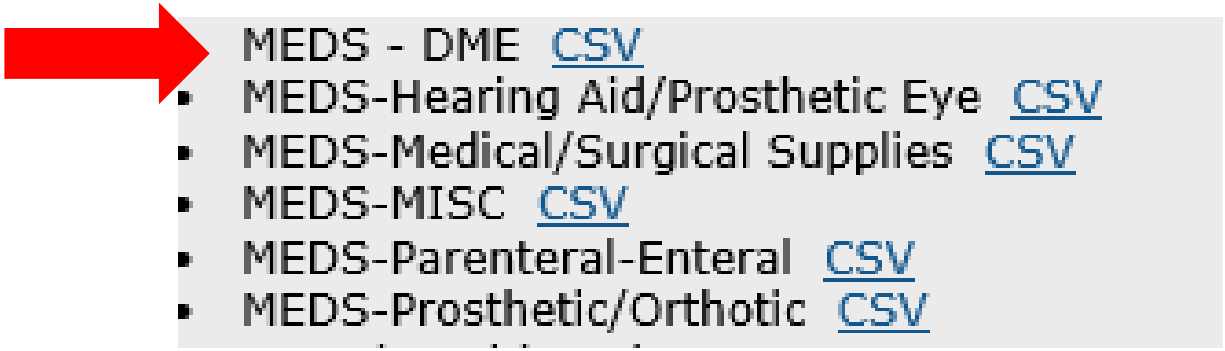
Locating the DSS Fee Schedule (cont.)

- Click on ***"Provider Fee Schedule Download"***



Locating the DSS Fee Schedule (cont.)

- Click on the ***"I Accept"*** button at the bottom of the License Agreement
- Choose the desired Provider Fee Schedule



Note: Non-customized wheelchairs are located under the DME Fee Schedule, which includes all E and K codes

Navigating the DSS Fee Schedule

- The columns on the Fee Schedule are as follows:

Procedure Code	Proc Description	Mod1	Mod1 Desc	Rate Type	Max Fee	Effective Date	End Date	PA	Qty

- If there is a “Y” in the ***“PA”*** column, prior authorization is required for that item

Modifiers

Modifier	Description
NU	New Equipment
UE	Used Equipment
RB	Replacement of a part of DME, orthotic, or prosthetic item furnished as part of a repair
RR NU	Rental New Equipment
RR UE	Rental Used Equipment
NR	New when rented and subsequently purchased
LL	Used rented equipment and subsequently purchased

Determining Rental vs. Purchase

- Items on the Fee Schedule that have an RR modifier must be rented prior to purchase
- The rental period can be up to three months

K0001	Standard wheelchair			DEF	390.26	3/1/2013	12/31/2299	Y	1
K0001	Standard wheelchair	RB		DEF	234.16	3/1/2013	10/31/2016		1
K0001	Standard wheelchair	RR		DEF	39.03	3/1/2013	12/31/2299	Y	1
K0002	Standard hemi (low seat) wheelchair			DEF	660.82	3/1/2013	12/31/2299	Y	1
K0002	Standard hemi (low seat) wheelchair	RB		DEF	396.49	3/1/2013	10/31/2016		1

Fee Schedule Changes

Wheelchair Components that Require PA

- As of July 1, 2017, certain wheelchair components require PA for repairs or modifications for wheelchairs (custom and non-custom) in order for claims to pay
- Providers must continue to submit clinical information supporting the medical necessity of the requested items
- For more information: PB 2017-21

New PA Codes

Code	Description
E0950	Wheelchair accessory, tray, each
E0951	Heel loop/holder, any type, with or without ankle strap, each
E0952	Toe loop/holder, any type, each
E0955	Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each
E0956	Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each
E0957	Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each
E0958	Manual wheelchair accessory one-arm drive attachment each
E0961	Manual wheelchair accessory, wheel lock brake extension (handle), each

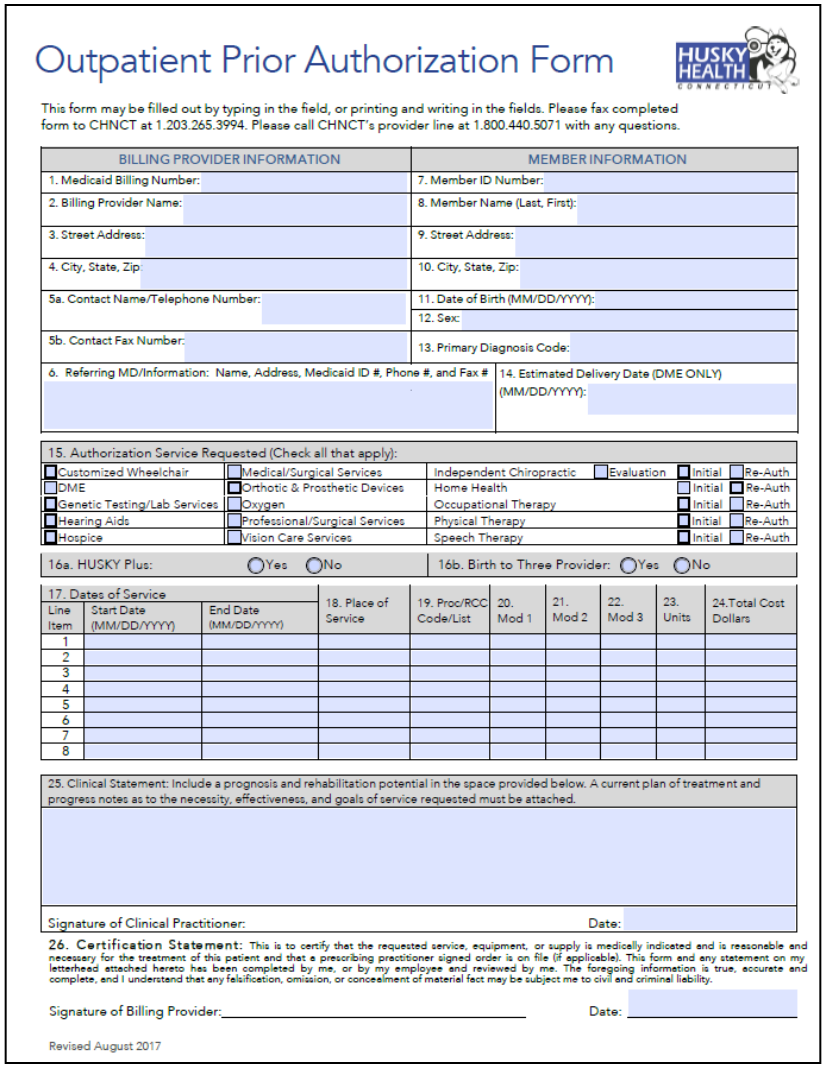
New PA Codes (cont.)

Code	Description
E0973	Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each
E0974	Manual wheelchair accessory, anti-roll-back device, each
E0978	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each
E0990	Wheelchair accessory, elevating leg rest, complete assembly, each
E0995	Wheelchair accessory, calf rest/pad, replacement only
E1028	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory
E2231	Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware
K0040	Adjustable angle footplate, each
K0042	Standard size footplate, replacement only, each

Submitting a PA Request

PA Form

- A current Outpatient PA Form can be found at www.ct.gov/husky
- Click "***For Providers***," "***Prior Authorization***," then "***Prior Authorization Forms & Manuals***"



Outpatient Prior Authorization Form

HUSKY HEALTH CONNECTICUT

This form may be filled out by typing in the field, or printing and writing in the fields. Please fax completed form to CHNCT at 1.203.265.3994. Please call CHNCT's provider line at 1.800.440.5071 with any questions.

BILLING PROVIDER INFORMATION	MEMBER INFORMATION
1. Medicaid Billing Number:	7. Member ID Number:
2. Billing Provider Name:	8. Member Name (Last, First):
3. Street Address:	9. Street Address:
4. City, State, Zip:	10. City, State, Zip:
5a. Contact Name/Telephone Number:	11. Date of Birth (MM/DD/YYYY):
	12. Sex:
5b. Contact Fax Number:	13. Primary Diagnosis Code:
6. Referring MD/Information: Name, Address, Medicaid ID #, Phone #, and Fax #	14. Estimated Delivery Date (DME ONLY) (MM/DD/YYYY):

15. Authorization Service Requested (Check all that apply):

☐ Customized Wheelchair	☐ Medical/Surgical Services	☐ Independent Chiropractic	☐ Evaluation	☐ Initial ☐ Re-Auth
☐ DME	☐ Orthotic & Prosthetic Devices	☐ Home Health		☐ Initial ☐ Re-Auth
☐ Genetic Testing/Lab Services	☐ Oxygen	☐ Occupational Therapy		☐ Initial ☐ Re-Auth
☐ Hearing Aids	☐ Professional/Surgical Services	☐ Physical Therapy		☐ Initial ☐ Re-Auth
☐ Hospice	☐ Vision Care Services	☐ Speech Therapy		☐ Initial ☐ Re-Auth

16a. HUSKY Plus: ◯ Yes ◯ No

16b. Birth to Three Provider: ◯ Yes ◯ No

17. Dates of Service

Line Item	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	18. Place of Service	19. Proc/RCC Code/List	20. Mod 1	21. Mod 2	22. Mod 3	23. Units	24. Total Cost Dollars
1									
2									
3									
4									
5									
6									
7									
8									

25. Clinical Statement: Include a prognosis and rehabilitation potential in the space provided below. A current plan of treatment and progress notes as to the necessity, effectiveness, and goals of service requested must be attached.

Signature of Clinical Practitioner: Date:

26. Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission, or concealment of material fact may be subject me to civil and criminal liability.

Signature of Billing Provider:_____ Date:

Revised August 2017

PA Form Completion

- You will need to complete all sections of the PA form including start date, end date, procedure code, modifiers, and number of units

17. Dates of Service			18. Place of Service	19. Proc/RCC Code/List	20. Mod 1	21. Mod 2	22. Mod 3	23. Units	24.Total Cost Dollars
Line Item	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)							
1									
2									
3									
4									
5									
6									
7									
8									

PA Form Completion (cont.)

- Dates
  - Start date is the date of delivery
  - Date span can be up to three months for a rental
  - Purchase requests can be up to one year
- Procedure Code
  - Verify the DSS Fee Schedule to determine the appropriate code
  - Code needs to match the description/code on the MD prescription

PA Form Completion (cont.)

- Modifiers
  - Include all appropriate modifiers for rental, purchase, new, or used equipment
- Units
  - For a rental, the number of units equals the number of months for the rental
  - For a purchase, the number of units equals one unit

Submitting a PA Request

- Providers may submit a prior authorization request by:
  - Fax: 203.265.3994 or
  - Medical Authorization Portal
    - For assistance: ClearCoverageHelpdesk@chnct.org

Clinical Documentation

Documentation Requirements

- Face-to-Face visit
- Prescription
- PA form

Face-to-Face Requirement

- Federal law requires a face-to-face visit with an enrolled physician, physician assistant (PA), or advanced practice registered nurse (APRN) in addition to the prescription order, for certain Durable Medical Equipment (DME) ordered on or after July 1, 2017
- No Medicaid payment will be issued for certain DME unless a face-to-face visit with an enrolled physician, PA, or APRN occurs
- For more information: PB 2017-19

DME List of Specified Covered Items

Face-to-Face Visit

- The face-to-face visit must:
  - Be related to the **primary reason** the HUSKY Health member requires the DME
  - Occur between the HUSKY Health member and a CMAP enrolled physician, PA, or APRN
  - Take place on or before the date of the prescription/order
  - Not be older than six months prior to the date on the prescription/order
  - Be on or before the date of delivery

Face-to-Face Documentation

- This documentation must, at a minimum, include all of the following:
  - The clinical findings of the face-to-face visit substantiating the need for the DME
  - The primary reason that the DME is required
  - The name (including either hard copy or digital signature) and credentials of the physician, PA, or APRN who conducted the face-to-face visit
  - The date of the face-to-face visit

Face-to-Face Special Note

- The practitioner who conducts the face-to-face visit does not have to be the same practitioner who signs the prescription
- However, as required by federal law, both practitioners must be CMAP enrolled
- A new face-to-face visit is required for the following:
  - All initial orders for the purchase or rental of specified DME items and/or related supplies
  - When a member has not had a face-to-face visit within six months of an initial order for the involved DME items
  - When there is a change in DME provider
- A new face-to-face is **not** required for replacement/broken wheelchairs

Prescription

- Per Section 17b-262-681(f) of the Regulations of Connecticut State Agencies, all DME prescriptions/orders shall include the following:
  - Member's name, address, and date of birth
  - Diagnosis for which the DME is required
  - Detailed description of the DME items(s), including quantities and any special option or add-ons
  - Length of need for the DME use
  - Prescribing practitioner's name, address, signature, and signature date and
  - NPI number of the ordering, prescribing, referring practitioner.

Rental Documentation

- Initial face-to-face visit within six months of order:
  - Must include the medical need for the requested wheelchair along with the member's current functional/ambulation status
- Prescription dated after the face-to-face visit
- Fully completed PA form

Rentals can be authorized for up to three months

Purchase Documentation

- Updated clinical documentation showing the medical need for continued long-term use of the wheelchair:
  - Letter of Medical Necessity from the ordering practitioner or an office visit note
  - A new face-to-face visit will be required if the documentation submitted is greater than six months old
- Original or updated prescription:
  - Prescriptions for DME are only valid for one year from the signature date
- Fully completed PA form

Authorization Special Notes

- Additional rental periods can be requested if the member has a short-term need for the equipment:
  - Example: Member has a four month weight-bearing restriction
    - An additional month rental can be requested
- Purchases for equipment for a short-term need:
  - If the member does not have medical need for long term use, authorization for a purchase will be denied
    - Example: Member has a four month weight-bearing restriction with no other comorbid conditions
      - It is not medically necessary for this member to have a purchase. Consideration may be made for a continued rental.

Urgent Requests

Definition of an Urgent Request

- Illnesses or injuries of a less serious nature than those constituting emergencies but for which treatment is required to prevent a serious deterioration in the individual's health, and for which treatment cannot be delayed without imposing undue risk to the individual's well-being until the individual is able to secure services from his/her regular physician(s).

Urgent Process

- Urgent requests will be reviewed within one business day
- Requests that do not meet the definition of urgent will be changed to expedited and will be reviewed within the 14 day turnaround time

Review Timeframe

Review Timeframe

- Once a request is submitted, a pending authorization number is generated
- If more information is needed, the clinical reviewer will contact the provider via fax, phone and/or email, or through their Clear Coverage™ account; if additional information is required, the provider is given additional time to submit the requested information
- All requests for DME are reviewed within 14 calendar days from the date of receipt
- A decision must be made by the 20th business day from the date of receipt

Request Approvals

- Approval letters are generated after the request approval has been given
- The approval letter is mailed to the member and faxed to the DME provider

Request Denials

- Denial letters are mailed to the member and faxed to the ordering physician and DME provider within three business days of the determination

Questions/Comments