Overview of the Prior Authorization Customized Wheelchairs E1220 Unbundling Process

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Connecticut Department of Social Services
Making a Difference

HUSKY HEALTH
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Objectives

- Improve understanding of the customized wheelchairs E1220 unbundling process for HUSKY Health prior authorization (PA)
- Access and use the Department of Social Services (DSS) Fee Schedule
- Minimize administrative burden associated with the E1220 unbundling process for PA
- Improve provider satisfaction with the PA process

Person-Centeredness

- Providing the member with needed information, education and support required to make fully informed decisions about his or her care options and to actively participate in his or her self-care and care planning
- Supporting the member, and their designated representative(s) in working together with his or her non-medical, behavioral health and medical providers and Care Manager(s) to obtain necessary supports and services
- Reflecting care coordination under the direction of and in partnership with the member and his/her representative(s) that is consistent with his or her personal preferences, choices and strengths and that is implemented in the most integrated setting

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

  (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

(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

Customized Wheelchair Prior Authorization Process

Submit a Prior Authorization Request

- Providers may submit PA requests for customized wheelchairs via:
  - Online - Clear Coverage Portal
  - Fax: 203.265.3994
- Continue to use the bundled E1220 code

E1220 Unbundling Process

- Community Health Network of Connecticut, Inc. (CHNCT) processes request as an E1220 code and staff will:
  - Manually unbundle E1220 code requests
  - Review provider pricing quotations
  - Cross-check all codes with the DSS Fee Schedule
  - Determine which codes require PA and how the PA will be given

E1220 Unbundling Process (cont.)

- Codes not requiring PA will not be entered into the authorization request
- Codes on the DSS Fee Schedule with a max fee will be entered in the authorization request and approved with units
- Codes on the DSS Fee Schedule with ZERO or List-15 will be entered in the authorization request and approved per a negotiated rate as outlined in the DSS MEDS Pricing Policy

The unbundling process was developed to help reduce the administrative burden for DME Providers

E1220 Unbundling Process
PA Requests

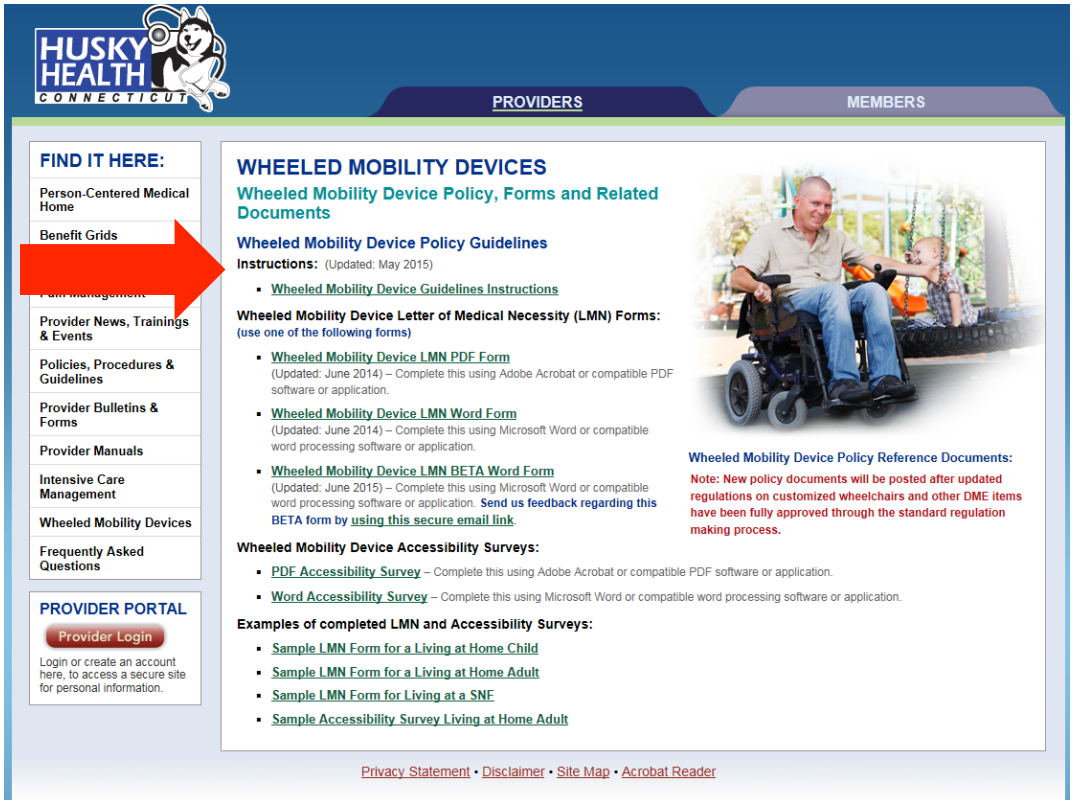
- Clear Coverage:
  - CHNCT will replace E1220 code with codes requiring PA as separate line items
  - Customized Wheelchair PA requests will have notes entered into Clear Coverage indicating eliminated codes and codes requiring PA
- Fax:
  - CHNCT will replace E1220 code with individual codes requiring PA

E1220 Unbundling Process Special Notes

- Individual authorizations are limited to 10 HCPCS codes or less
- Authorizations requiring more than 10 HCPCS codes for PA (according to the DSS Fee Schedule), will be split into 2 separate authorizations
- Clear Coverage E1220 requests with more than 10 HCPCS codes may have:
  - Original authorization that can be viewed in the portal
  - 2nd authorization that was manually entered by CHNCT that **cannot** be viewed in the portal

Wheeled Mobility Device Policy Guidelines

- Go to www.ct.gov/husky, click ***"For Providers,"*** ***"Wheeled Mobility Devices,"*** then ***"Wheeled Mobility Device Policy Guidelines"***



Review the policy frequently for any changes

National Correct Coding Initiative Medically Unlikely Edits

- A Medically Unlikely Edit (MUE) is a unit of service edit for a HCPCS/CPT (Current Procedural Terminology) code that applies to services performed by the:
  - ***Same provider***
  - ***For the same beneficiary***
  - ***On the same date of service***
- Centers for Medicare and Medicaid Services (CMS) MUE tables:

  https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/mcd-mue-dmesupplierservices.zip
- Quarterly additions, deletions and revisions are posted

National Correct Coding Initiative Medically Unlikely Edits (cont.)

- Effective April 1, 2015, claims exceeding MUE will:
  - Auto-deny instead of cutback
  - Post Explanation of Benefits (EOB) code 0770 “MUE UNITS EXCEEDED”
- Providers are responsible for identifying codes with an MUE prior to submitting a PA

If a code has an MUE, claims will deny regardless of authorization

NCCI Procedure to Procedure Edits

Provider Bulletin 2012-40 notified MEDS providers that DSS has implemented Medicaid-Only Procedure to Procedure (PTP) edits related to wheelchairs:

- Made consistent with NCCI updates received from CMS
- Promote correct coding and control improper coding that could lead to inappropriate payments
- Find NCCI edits on the CMS website:

  http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html
- Review edits frequently for quarterly updates

NCCI Procedure to Procedure Edits (cont.)

Wheelchair Edits Groups	
Group 1	Wheelchair bases with other wheelchair bases
Group 2	Wheelchair bases with other wheelchair options and accessories
Group 3	Wheelchair bases with wheelchair seating
Group 4	Wheelchair options and accessories with other wheelchair options and accessories
Group 5	Wheelchair seating with other wheelchair seating

NCCI Procedure to Procedure Edits (cont.)

- Each of the wheelchair base codes will be paired with each of the other codes, resulting in thousands of unique code pairs/PTP edits
- The methodology assigns codes based on the technical complexity of the item
  - Example: Power wheelchairs were ranked higher than power operated vehicles (POVs/scooters) which were ranked higher than manual wheelchairs
- The same concept will be applied to wheelchair bases, wheelchair options and accessories, and wheelchair seating in groups 2 through 5
- This will prevent a particular accessory to be used with a specific type of wheelchair (e.g., a battery is not used with a manual wheelchair)
- An accessory repair part could not be billed at the time of initial issue of the wheelchair (e.g., a replacement motor is not payable with a power wheelchair base code)

NCCI Procedure to Procedure Edits Claim Denials

- Incorrect code combinations submitted on claims will deny
- One of the following edits will appear on the EOB:
  - **5924** – Claim denied, Correct Coding Initiative (CCI) greater and lesser procedures are not covered on same date of service
  - **5925** – CCI column 1 code or mutually exclusive code was billed on same date as previous column 2 code
  - **5926** – CCI column 2 code was billed on the same date as previous column 1 or mutually exclusive code
- Authorization of customized wheelchair components is not a guarantee of payment
- Providers are responsible for identifying procedure code combinations that may not be billed on the same date of service

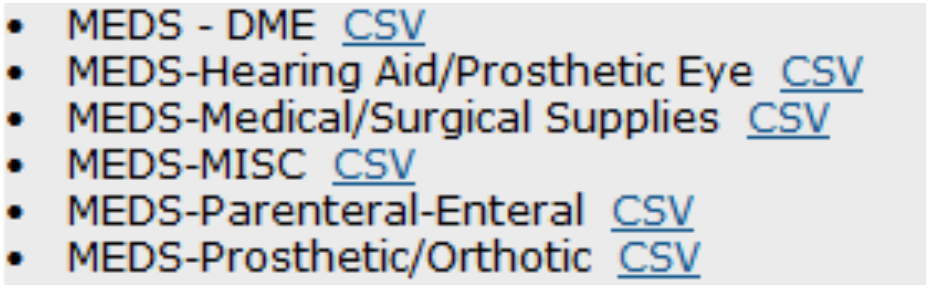
Code combinations not allowed based on NCCI edits will deny regardless of authorization

DSS Fee Schedule & Unbundling

DSS Fee Schedule

- Go to www.ctdssmap.com
- Click on ***"Provider"***
- Click on the ***"I Accept"*** button at the bottom of the License Agreement
- Choose the desired Provider Fee Schedule:

"MEDS – DME" is where E and K codes are found



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, then Prior Authorization is required for that item

DSS Fee Schedule/Unbundling
No PA Needed

- Code Example: No PA required

TiSport	**X2FTR7**	**1 Piece Over Center Folding Footrest**		**K0037 NU**	**EA**	**1**	

K0037	**High mount flip-up footrest each**			**DEF**	**38.89**	**3/1/2013**	**12/31/2299**	

PA Column is blank

DSS Fee Schedule/Unbundling PA Needed for Units

- Code Example: Requires PA and has a max fee

1	**Each**	**EZ14 – EZ RIDER** **900301**	**E1236 NU**

E1236	**Wheelchair pediatric size folding adjust**			**DEF**	**1401.12**	**3/1/2013**	**12/31/2299**	**Y**

Max Fee Allowed

PA is required

DSS Fee Schedule/Unbundling PA Needed for Negotiated Fee

- Code Example: Requires PA and manual pricing

Permobil, Inc.	**I11110**	**Power Adjustable Seat Height – 12” Travel**	**E2300**	**NU**

E2300	Wheelchair accessory power seat elevate			DEF	Zero	7/1/2004	12/31/2299	Y

Requires manual pricing
Approved with negotiated fee

PA is required

DSS Fee Schedule/Unbundling
PA Needed for Miscellaneous Code

- Code Example: Miscellaneous code requiring PA and manual pricing

1	**Each**	**2pc Wide Corpus VS Footplates – 9”D x 7.5”W - LEGREST OPTIONS**	**K0108 NU**

K0108	Wheelchair component or accessory not			DEF	Zero	5/1/2009	12/31/2299	Y

Requires manual pricing
Approved with negotiated fee

PA is required

DSS Fee Schedule/Unbundling Example 1

Provider Quotation

Quantum Rehab			
1	Each	J6 2SP-SS – BASE MODEL	K0835
1	Each	Swing-away, Inline, Right – JOYSTICK MOUNTING BRACKETS SAMTIR7	E1028
1	Each	TRU-Balance 2 Power Tilt – TRU-Balance 2 SEATING SYSTEM	E1002
1	Each	Adjustable Center Mount Foot Platform, 10-8” Footplate – ADJUSTABLE CENTER MOUNT FOOT PLATFORM	K0108
1	Pair	Calf Pads, Large – ADJUSTABLE CENTER MOUNT FOOT PLATFORM	K0108
2	Each	U-1 32 amp Batteries - BATTERIES	E2365
Motion Concepts			
1	Each	16” w 16-17” d – MaTRx LIBRA CUSHION, STARTEX LC1616	E2624

Authorization

- No PA needed: ***E1028***, ***E2365***
- PA with units: ***K0835***, ***E1002***, ***E2624***
- PA with negotiated fee: ***K0108***

DSS Fee Schedule/Unbundling Example 2

Provider Quotation

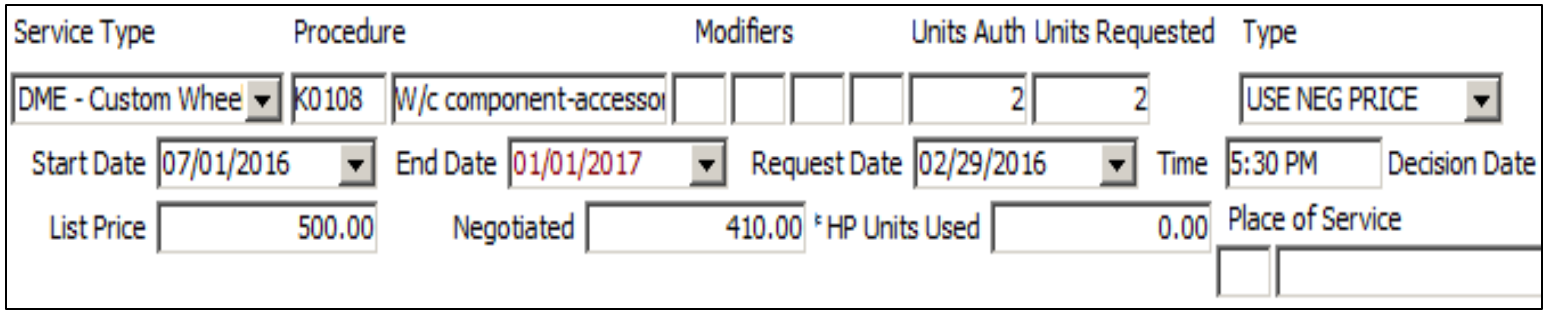
Description	Code
F3 Base Corpus – F3 MPO	K0861
Anti-Tippers for F3 / F5	K0108
Corpus Seat w/50° Tilt & 175° Power Recline	E1007
Functional Reach Package - 20° Anterior Tilt	K0108
Batteries, Grp 24 (72Ah) Sealed Gel	E2363
Power Adjustable Seat Height – 12” Travel	E2300
Harness for Expandable Controller	E2313
R-net Remote Color Joystick – Programmable	K0108
Retractable Joystick Mount Right-R-Net VR2	E1028
BodyPoint J/S Handle 4” UShaped w/FlexShaft	E2323
Expandable Controller-R-Net	E2377
Multiple Seat Function Control Kit For R-Net	E2311
Corpus Ergo Back 18W x 23-28T	E2620
Corpus 3G Ergo Seat Cushion	E2605
Adj Removable Knee Support Hardware	E1028
2pc Wide Corpus VS Footplates – 9”D x 7.5”W	K0108
I107186-99-0 Corpus VS Power Elevating Legrest 180	K0108

Authorization

- No PA needed:
  E2363, ***E2313***, ***E2323***, ***E1028***
- PA with units:
  K0861, ***E1007***, ***E2377***, ***E2311, E2620***, ***E2605***
- PA with negotiated fee: ***K0108***, ***E2300***

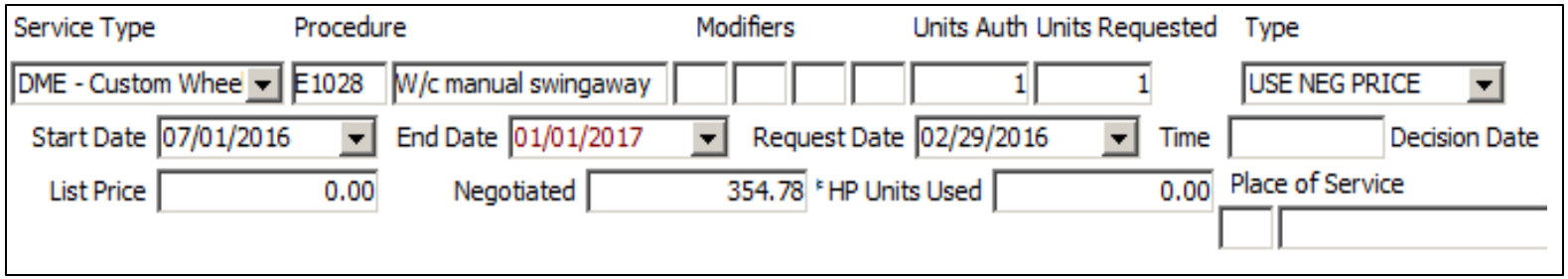
DSS Fee Schedule/Unbundling Miscellaneous Code K0108

- ***K0108*** codes entered with the number of units requested with the negotiated price:
  - The negotiated pricing will be the sum of each ***K0108*** code
- Claims must be submitted exactly as the authorization appears



DSS Fee Schedule/Unbundling Quantity Limits

- If a code does not require PA for a quantity of 1 and you are requesting a higher quantity, PA will be needed
- On a case by case basis, the requested code may be authorized with a negotiated fee if it is over the DSS Fee Schedule quantity limit
- You will need to verify with CMS if the requested code has an MUE
- PA will not override an MUE established by CMS



DSS Fee Schedule/Unbundling Quantity Limits & Modifiers

- Bilateral postural components:
  - Example: Code ***E0956*** has a quantity limit of 2 and does not require PA
  - If a member requires bilateral lateral thoracic supports and hip guides, you will need to specify modifier “RT” and “LT” to allow claims to pay for a quantity of 4
  - PA is not required

E1220 Unbundled Approvals

- Approval letters detail each line item approved that requires PA
- Claims must be submitted exactly as the authorization appears, if not, the claim will not pay

Member Name:
Member Date of Birth:
Member ID Number:
Plan:
Provider CMAP:
Notification Number:
Services Approved: K0005 Ultralightweight Wheelchair 1 Units 07/01/2016 to 01/01/2017
Services Approved: K0108 W/c Component-Accessory Nos 1 Use Neg Price $410.00 07/01/2016 to 01/01/2017
Services Approved: E1018Hd Shck Absrber For Hd Powwc 1 Use Neg Price $2,000.00 07/01/2016 to 01/01/2017

E1220 Unbundled Partial Denials

The notification process for Partial Denials is changing on 7/1/16:

- Partial Denials defined as approved for “part” of a code **and** denied for “part” of the same code
- Example:
  - 4 ***K0108*** HCPCS codes were requested; 1 ***K0108*** HCPCS was approved and 3 were denied
- Authorizations will show each line item approval

E1220 Unbundled Partial Denials (cont.)

- Partial Denial notifications detail each line item that requires PA

Member Name:
Member Date of Birth:
Member ID Number:
Plan:
Authorization Start Date:
Authorization End Date:
Notification Number:
Services Approved: E1161 Manual Adult Wc W Tiltinspac 1 Units 07/01/2016 to 01/01/2017
Services Approved: K0108 W/c Component-Accessory Nos 1 Use Neg Price $205.00 07/01/2016 to 01/01/2017

Dear:

The HUSKY Health Program has received a request for authorization for **DME - Custom Wheelchair** for our member. Based on the information provided, we are unable to authorize all of the services in the amount/duration requested for the following reason: Not medically necessary as it It is not the right type or amount for the member.

E1220 Unbundled Denials

Denials are defined as **either** a line item that is fully denied **or** an entire wheelchair that is fully denied

- If the entire wheelchair is denied, the denial letters will remain unchanged
- For requests where line items are fully approved **and** line items are fully denied:
  - The approval line items will be separated from the denied line items
  - Provider will receive 2 separate notifications:
    - Approval letter detailing approved line items
    - Denial letter detailing denied components with denial rationale

Please note: PA requests submitted through Clear Coverage will be cancelled and re-entered to reflect an approval and denial

Contact Information

- For questions about billing or help accessing the fee schedule, contact:

  HP Provider Assistance Center

  Phone: 1.800.842.8440

  Hours: Monday through Friday, 8:00 a.m. to 5:00 p.m.

- For questions about Prior Authorization, contact:

  CHNCT

  Phone: 1.800.440.5071

  Hours: Monday through Friday, 8:30 a.m. to 6:00 p.m.

Questions?