Prior Approval Process for Enrollees Eligible for Both Medicare and Medicaid

for Durable Medical Equipment, Prosthetic, Orthotic and Supply Items

Effective January 2009, this article will serve as a revision to the policy and procedures outlined in the August 2007 Medicaid Update on this subject.

A. POLICY

Medicaid law and regulation require that when an enrollee is eligible for both Medicare and Medicaid benefits (i.e., dually eligible), the provider must bill Medicare first for covered services prior to submitting a claim to Medicaid for coinsurance and deductible. Prior approval from Medicaid is not required when billing Medicare coinsurance and deductible for services otherwise requiring prior approval for Medicaid-only enrollees.

B. EXCEPTIONS

When a Durable Medical Equipment, Prosthetic, Orthotic, and Supply (DMEPOS) item requires prior approval for Medicaid-only enrollees, a medical prior approval determination for a dually-eligible enrollee may be requested under the situations listed below. When required, the provider must furnish conclusive documentation with a Medicaid prior approval request that an appeal for reconsideration of a Medicare claims denial has been submitted to and denied by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

1. ITEM IS STATUTORILY NON-COVERED BY MEDICARE

When a DMEPOS item is statutorily never covered by Medicare (e.g., bathing equipment) and is covered by Medicaid, a prior approval request may be submitted to Medicaid along with documentation of medical necessity. It is not necessary to submit claims to Medicare before requesting Medicaid prior approval in this situation.

2. SAME OR SIMILAR EQUIPMENT

When the DME MAC issues a claim denial because the Medicare beneficiary has received a product within the last five years which has the same or similar therapeutic benefit for the same medical condition, the provider must include documentation of the DME MAC denial with any Medicaid prior approval request. The prior approval request must include any information available to the provider about the item or items that caused the current Medicare claim to be rejected. Based upon this information Medicaid will make an independent determination of current medical necessity and appropriateness with respect to the requested item.

3. PRODUCTS USED OUTSIDE THE HOME

When the DME MAC issues a claim denial because a requested item is not being used "in the home", the provider must submit documentation of the DME MAC claim rejection with any Medicaid prior approval request. The prior approval request must also contain any information available to the provider about products supplied under Medicare reimbursement for the beneficiary's use in the home. Medicaid will review prior approval requests for non-ADMC powered wheeled mobility bases prior to Medicare claim submission if the base is not to be used in the home.

4. PRODUCTS IN EXCESS OF THE ALLOWED MAXIMUM

When the DME MAC issues a claim denial because the physician's order for a Medicare covered item requests quantities that exceed Medicare payment screens, the provider must submit documentation of the denial with any Medicaid prior approval. The provider must then proceed to appeal that denial to the DME MAC and maintain a copy of the DME MAC's determination on the appeal in the provider's records for any Medicaid post-audit purposes.

5. ADVANCE DETERMINATION OF MEDICARE COVERAGE (ADMC)

Unlike most services, certain customized or specialized wheeled mobility bases are eligible for a Medicare ADMC review prior to provision of service. When Medicare issues a negative ADMC decision which communicates that the beneficiary does not meet Medicare coverage criteria established for the base equipment, Medicaid will review a prior approval request. The request must include a copy of the ADMC and all the supporting documentation required by and submitted to Medicare*. This process is not to be utilized when the ADMC states that documentation submitted to Medicare was not sufficient for a determination to be made or when Medicare procedure and documentation requirements have not been met or followed. When a particular item is eligible for ADMC, all options and accessories ordered by the physician for that patient, along with the base HCPCS code, are eligible for ADMC. The current list of codes available for ADMC is:

- Manual wheelchairs described by codes: E1161, E1231-E1234, K0005, and K0009.
- Group 2, 3, 4 or 5 Single Power Option or Multiple Power Options wheelchair (K0835-K0843, K0856-K0864, K0877-K0891) – whether or not a power seating system will be provided at the time of initial issue.
- Group 3 or 4 No Power Option wheelchair (K0848-K0855, K0868-K0871) that will be provided with an alternative drive control interface at the time of initial issue.

*****Refer to the DME MAC Supplier Manual:
http://www.medicarenhic.com/dme/dmemaca_sm_ch10-rev2008-07.pdf

C. PAYMENT

- If requests are approved, Medicaid will issue a prior approval in the amount of $1.00 pending resolution of the appeal of the adverse Medicare coverage determination to the DME MAC. Once a DME MAC denial is received in prior approval, Medicaid payment will be made according to the applicable Medicaid pricing policy.

- When an item requires DVS, the vendor should obtain the authorization number prior to dispensing and billing Medicare. If Medicare denies the claim and the appeal, providers may bill Medicaid with the DVS number. If Medicare does pay, the vendor should cancel the DVS authorization so that future DVS service limits are not exceeded.

- If the DME MAC approves the item on appeal, a bill may be submitted directly to Medicaid indicating the Medicare Approved and Medicare Paid amounts. When the DME MAC approves such a request on appeal, DO NOT enter the Medicaid prior approval or DVS number issued to you on your Medicaid claim.

- If New York State Medicaid issues a prior approval or DVS number and a subsequent decision by Medicare results in a Medicare payment to the provider, the provider is required to adjust any Medicaid paid claims to reflect the Medicare Approved and Medicare Paid amounts received in conformity with Department of Health Regulation at Title 18 of the New York Code of Rules and Regulations Section 540.6.

Questions? Please contact the Division of Provider Relations and Utilization Management at:
1-800-342-3005 option 1