



Durable Medical Equipment PowerPoint Presentation

Magnolia Health Plan

9/10/2018

Medical Supplies, Equipment, and Appliance Update



- This notice serves as additional guidance regarding the information provided in the notification issued by the Mississippi Division of Medicaid in May 2018 regarding reimbursement for medical supplies, equipment and appliances ordered by non-physician practitioners effective September 1, 2018. According to written guidance, CMS will defer to Mississippi's collaborative practice agreement procedures regarding the ordering of medical supplies, equipment and appliances. Therefore, if the collaborative agreement allows the non-physician practitioner to order medical supplies, equipment and appliances, the non-physician practitioner's signature on the order is sufficient and the collaborating physician is not required to sign or co-sign that order for the medical supplies, equipment and appliances to be covered under the Magnolia CHIP and MSCAN program(s).
- ***The servicing provider must include the collaborating physician's national provider identifier (NPI) number and Mississippi Medicaid number on (1) any required CMN submitted for prior authorization and (2) all claims submitted in accordance with 42 C.F.R. 455.440.*** As a reminder, 42 C.F.R. 455.410 requires that all ordering or referring physicians must be enrolled as Mississippi Medicaid providers.

Please see the link to the Mississippi Division of Medicaid's DME Provider Frequently Asked Questions (FAQ) document: <https://medicaid.ms.gov/dme-provider-frequently-asked-questions/>.

Verify Eligibility



It is highly recommended to verify member eligibility on the date services are rendered due to changes that occur throughout the month, using one of the following methods:

Log on to the Medicaid Envision website at:

www.ms-medicaid.com/msenvision/

Log on to the secure provider portal at

www.MagnoliaHealthPlan.com

Call our automated member eligibility interactive voice response (IVR) system at 1-866-912-6285

Call Magnolia Provider Services at 1-866-912-6285

(MEMBER ID CARDS ARE NOT A GUARANTEE OF ELIGIBILITY AND/OR PAYMENT)

Benefits and Limitations – MSCAN



DME

- Durable Medical Equipment is covered in accordance to the Medicaid guidelines.
- Magnolia reimburses 100% of Medicaid benefits for participating providers. Non-participating providers will be reimbursed 50% of Medicaid's fee schedule with a prior authorization.
- Authorization is required for some DME. Providers should utilize the Pre-Auth Check Tool to determine if the HCPCS code requires authorization.
- DME is covered based on medical necessity.

Orthotics and Prosthetics (O&P)

- O&P are covered for members under the age of 21.
- Items categorized as orthotics are sleeves or braces.
- Items categorized as prosthetics are items physically attached to the body (legs, hands, arms, etc.).
- Orthotics and Prosthetics will be authorized by HCPCS codes. Providers will need to utilize the Pre-Auth Check Tool to determine if a Prior Authorization is required.

Fee Schedule and Policy



You may access the fee schedule on the DME page of the MS Medicaid website:

<http://medicaid.ms.gov/DMEandMedSupply.aspx>

Detailed policy manuals are available in Section 209 of the Administrative Code Policy Manuals and can be retrieved at the following link:

<https://medicaid.ms.gov/providers/administrative-code/>

Benefits and Limitations – CHIP



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Mississippi Children's Health Insurance Program

DME

- Durable Medical Equipment is covered in accordance to the MS CHIP guidelines.
- Magnolia reimburses 100% of benefits for participating providers.
- Authorization is required for some DME. Providers should utilize the Pre-Auth tool to determine if the HCPCS code requires authorization.
- DME is covered based on medical necessity.

Orthotics and Prosthetics (O&P)

- O&P are covered for all members.
- Prior authorization is required. Out of network benefits are reimbursed at 100%.
- Items categorized as prosthetics are items physically attached to the body (legs, hands, arms, etc.).
- Orthotics and Prosthetics will be authorized by HCPCS codes. Providers will need to utilize the Pre-Auth tool to determine if a Prior Authorization is required.



Pre-Authorization Tool



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Medicaid Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services, including all services rendered by an Optician, Ophthalmologist or Optometrist need to be verified by [Envolve Vision](#)

Dental services need to be verified by [Envolve Dental](#)

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)

Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by [NIA](#)

Non-participating providers must submit Prior Authorization for all services.

For non-participating providers, [Join Our Network](#).

Basic laboratory chemistries and basic radiology do NOT require prior authorization for participating or non-participating providers.

Are Services being performed in the Emergency Department or Urgent Care Center, FQHC or RHC, or Family Planning services billed with a V25 to V25.9 diagnosis?

Yes No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input type="radio"/>
Are anesthesia services being rendered for pain management or dental surgeries?	<input type="radio"/>	<input type="radio"/>
Is the member receiving hospice services?	<input type="radio"/>	<input type="radio"/>
Are services other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	<input type="radio"/>	<input type="radio"/>

To submit a prior authorization [Login Here](#).

Prior Authorization Process



- Services that require authorization can be found on Magnolia's website. www.magnoliahealthplan.com
- The authorization process should be initiated at least **5** days in advance for *non-emergent* services
- Contact the UM department via phone, fax, e-mail, mail or through the secure web portal with the appropriate clinical information to request an authorization

(Emergency room and urgent care services never require prior authorization)

Where do I send my PA request?



Prior Authorization Form(s) can be located on our website at:

<http://www.magnoliahealthplan.com/for-providers/provider-resources/>

FAX

Requests can be faxed to:
1-877-291-8059 (MSCAN Inpatient)
1-877-650-6943 (MSCAN Outpatient)
1-855-684-6747 (CHIP)

WEB

Requests can be made securely at:
magnoliahealthplan.com/login/

Mail

Requests can be mailed to:
Magnolia Health Plan
Attn: Utilization Management
111 E. Capitol Street, Suite 500
Jackson, MS 39201

EMAIL

Requests can be emailed securely to:
magnoliaauths@centene.com

PHONE

Requests can be phoned in to:
1-866-912-6285 (MS CAN/CHIP)

Durable Medical Equipment (DME) Payment/Reimbursement Policies

The payment for purchase of new durable medical equipment is made from a statewide uniform fee schedule which is updated by July 1 of each year and is effective for services provided on or after that date based on one of the following instances:

- The lesser of the provider's usual and customary charge or:
- 80% of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DEMPOS) fee schedule in effect by January 1.
- If no DEMPOS fee is available and a fee cannot be calculated the item will be manually priced at the Manufacturer's Suggested Retail Price (MSRP) minus 20% to provide the 80% price range that is offered by Medicare. (Items that do not have a fee or MSRP may be priced at the provider's cost plus 20 %.)

Reimbursement



- The payment for the rental of DME is made from a statewide uniform fee schedule which is based on 10% of the purchase allowance for new DME not to exceed 10 months. After the rental benefits are paid for 10 month, the equipment becomes property of the beneficiary/member unless, otherwise authorized by the Division of Medicaid through specific coverage criteria.
- The payment for purchase of used DME also follows the uniform fee schedule and cannot exceed more than 50% of the new DME purchase allowance.
- The payment of repair of DME equipment also cannot exceed 50% of the new DME purchase allowance.
- The payment for other individual consideration items must receive prior authorization from the Utilization Management Department.

Payment method for manually priced items:



Most manually priced items are priced at the MSRP minus 20%.

- You must submit clear, written, and dated documentation from a manufacturer or distributor that specifically states the MSRP for the item. The documentation must be provided with an official manufacturer's or distributor's letterhead, price list, catalog, or other forms that clearly show MSRP.
- We will accept a quote from the manufacturer or distributor if the manufacturer does not make an MSRP available. The quote must be in writing and must be dated.
- The payment of repair of DME equipment also cannot exceed 50% of the new DME purchase allowance.

If the item does not have an MSRP or fee they may be priced at the provider's cost plus 20%.


- You must attach a copy of the current invoice indicating the cost to you for the item and a statement showing that there was no MSRP available for the item.
- If purchased from a manufacturer, a manufacturer's invoice is required.
- If purchased from a distributor, a distributors' invoice is required.
- Quotes, catalog pages, printouts, price lists, or any form of documentation other than an invoice are **NOT** acceptable.
- The invoice must not be older than one year prior to the date of request.

Claims Filing – MSCAN



- ALL Claims must be filed within **six (6) months** of date of service.
- ALL requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within **ninety (90) days** from the date of notification of denial.
- Option to file electronically through the clearinghouse
- Option to file directly through the Magnolia website
- All member and provider information must be complete and accurate.

File online at
www.magnoliahealthplan.com


- Option to file on paper claim, please mail to:
Magnolia Health Plan MSCAN
Attn: CLAIMS DEPARTMENT
P.O. Box 3090
Farmington, MO 63640 
- Paper claims are to be filed on approved UB-04 (CMS 1450) claim forms (**No handwritten or black and white copies**)
- To assist our mail center improve the speed and accuracy of complete scanning, please take the following steps when filing paper claims:
 - ✓ Remove all staples from pages
 - ✓ Do not fold the forms
 - ✓ Make sure claim information is dark and legible
 - ✓ Please use a 12pt font or larger
 - ✓ Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster.

Claims Filing – CHIP



- ALL Claims must be filed within **six (6) months** of date of service.
- ALL requests for correction, reconsideration, retroactive eligibility, or adjustment must be received within **ninety (90) days** from the date of notification of denial.
- Option to file electronically through the clearinghouse
- Option to file directly through the Magnolia website
- All member and provider information must be complete and accurate.

File online at
www.magnoliahealthplan.com

- Option to file on paper claim, please mail to:
Magnolia Health Plan CHIP
Attn: CLAIMS DEPARTMENT
P.O. Box 5040
Farmington, MO 63640 
- Paper claims are to be filed on approved UB-04 (CMS 1450) claim forms (**No handwritten or black and white copies**)
- To assist our mail center improve the speed and accuracy of complete scanning, please take the following steps when filing paper claims:
 - ✓ Remove all staples from pages
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 - ✓ Red and White approved claim forms are required when filing paper claims as our Optical Character Recognition ORC scanner system will put the information directly into our system. This speeds up the process and eliminates potential sources for errors and helps get your claims processed faster.

Corrected Claim, Reconsideration, Claim Dispute – MSCAN and CHIP



All requests for corrected claims, reconsiderations or claim disputes must be received within **ninety (90) days** of the last written notification of the denial or original submission date.

Corrected Claims

- Submit via Secure Web Portal
- Submit via an EDI Clearinghouse
- Submit via paper claim:
- Submit corrected claims to along with the original EOP to:
 - Magnolia Health Plan
 - PO BOX 3090 (MSCAN)
 - PO BOX 5040 (CHIP)
 - Farmington, MO 63640

Reconsideration

- Written communication (i.e. letter) outlining disagreement of claim determination
- Indicate “Reconsideration of (original claim number)”
- Submit reconsideration to:
 - Magnolia Health Plan
 - Attn: Reconsideration
 - PO BOX 3090 (MSCAN)
 - PO BOX 5040 (CHIP)
 - Farmington, MO 63640
- **If your claim denied for no authorization on file, please include the reason why a PA was not obtained in your request for reconsideration.**

Claim Dispute

- ONLY used when disputing determination of Reconsideration request
- Must complete Claim Dispute form located on www.magnoliahealthplan.com
- Include original request for reconsideration letter and the Plan response
- Send Claim Dispute form and supporting documentation to:
 - Magnolia Health Plan
 - Attn: Claim Dispute
 - PO BOX 3090 (MSCAN)
 - PO BOX 5040 (CHIP)
 - Farmington, MO 63640

Provider Services (Call Center)



Mississippi Based Provider Services Call Center:

- Provides phone support
- **First line of communication**
- Answer questions regarding eligibility, authorizations, claims, payment inquiries
- Available Monday through Friday, 8am to 5pm CST

1-866-912-6285 (CAN/CHIP)

