Acentra HEALTH

Durable Medical Equipment

Provider Education 2024

Partners in Healthcare – Who are we?

- Acentra Health (formerly Kepro and CNSI) is the Utilization Management/Quality Improvement Organization (UMQIO) for the South Carolina Department of Health and Human Services (SCDHHS) Healthy Connections Fee For Service Medicaid program. We have been providing services for SCDHHS since 2012.
- We are a team of experienced leaders, caring clinicians, pioneering technologists, and industry professionals who come together to redefine expectations for the industry.
- We provide:
  - Medical necessity reviews for multiple services
  - Level of Care reviews
  - Post-Payment reviews

CMS-Certified Solutions

CMMI Level 4 Appraisal

URAC Accredited

HITRUST Certified

Durable Medical Equipment

As defined by SCDHHS

"Durable Medical Equipment (DME) is equipment that provides therapeutic benefits or enables beneficiaries to perform certain tasks that they are unable to undertake otherwise due to certain medical conditions and/or illness…..DME includes equipment such as wheelchairs, hospital beds, traction equipment, canes, crutches, walkers, ventilators, oxygen, prosthetic and orthotic devices and other medically needed items."

https://provider.scdhhs.gov/internet/pdf/manuals/DME/Manual.pdf

Durable Medical Equipment

- Medicaid will pay for a service or item when the service or item is covered under the South Carolina Sate Plan, is medically necessary and is appropriate for use in any setting in which normal life activities take place.
  - Please refer to the DME Fee Schedule on the SCDHHS website for covered equipment and supplies codes https://www.scdhhs.gov/providers/fee-schedules

- Medically Necessary means the service is directed toward the maintenance, improvement or protection of health, or toward the diagnosis and treatment of illness or disability.

- Convenience items are not covered.

- The fact that a provider has prescribed, recommended or approved medical or allied care, goods or a service does not make such care, goods, or services medically necessary or a covered service.

- Miscellaneous codes will only be used when there is no available code that best describes the product or service being billed. Providers may not use a miscellaneous code to “bypass” an established code because of pricing or coverage issues.

Important Updates

Power Wheelchair Elevation Systems

Effective 4/1/2024

- **E2300 was terminated on March 31, 2024**
- **E2298 “complex rehabilitative power wheelchair accessory, power seat elevation system, any type” replaced E2300 on April 1, 2024.**
  - **It is a covered benefit**
  - **No age limit**
- **E2298 is in the Capped Rental category**

- **If you submitted an authorization request in March for E2300 but delivery was 4/1/24 or after, please submit an authorization revision via Atrezzo so we may review for coverage determination with E2298. Please be specific in your request, provide the code, updated CMN and date of delivery.**

Important Updates

Bowel Management Systems
A4459 and A4453

- A4459 – Manual Pump-operated enema system, includes balloon, catheter, and all accessories, reusable, any type
- A4453 – Rectal catheter for use with the manual pump=operated enema system, replacement only
- Atrezzo has been updated to allow for A4453 to be submitted for review
- Per SCDHHS:
  A4459 allows 1 per 3 months or 4 in a 12-month period
  A4453 allows 2 units per month
  - Unit is a box of 15 catheters

Important Updates

Continuous Glucose Monitoring
A4238, A4239, A9276, A9277, A9278, E2102, E2103

- Effective July 1, 2024, SCDHHS will expand coverage for continuous glucose monitoring devices and supplies to all beneficiaries with full benefits. Acentra Health will continue to use InterQual® criteria in addition to the requirements below.

- CGM must be prescribed by the following qualified healthcare provider:
  - Primary Care provider (physician, physician assistant, advance practice registered nurse)
  - Obstetrician
  - Endocrinologist

- Member must have one of the following clinical criteria:
  - Type 1 diabetes mellitus
  - Gestational diabetes
  - Type 2 diabetes with one of the following
    - >any type of insulin dependency
    - >Non-insulin treated diabetes who have recurrent moderate (Level 2) or at least one severe (Level 3) hypoglycemic event

Prior Authorization Requests

Authorization requests should always be submitted prior to services being delivered

Providers are responsible for verifying eligibility and/or MCO enrollment prior to submitting PA requests

Authorization requests may be submitted online at https://portal.kepro.com or by fax using the SCDHHS Outpatient Prior auth request form.

For assistance with the Atrezzo portal please call 1-855-326-5219

Beneficiaries with other health insurance do not require a PA from Acentra Health UNLESS requested service is a non-covered service or benefits have been exhausted by primary insurance.

An explanation of benefits or statement of non-covered benefit is required before a PA can be issued.

Authorization Types

❑ Prior Authorization

Should always be submitted on or before the equipment and/or supplies are delivered

❑ Retrospective Authorization "Retro"

Needed when services were performed **before** the member was eligible for Medicaid and the member has since been granted retrospective eligibility covering the date of service.

- A Retro case is NOT one that is submitted late for any reason other than eligibility.
- Untimely requests will be administratively denied.
- Providers must identify a request as RETRO on the fax request form or by request type in Atrezzo.

Documenting Medical Necessity

Acentra Health requires the following information to be submitted with a request for authorization:

- Completed Outpatient PA request form (unless using the web portal to submit case)
- Copy of the physician’s order
- All pertinent medical documentation for the patient that supports medical necessity
- Certificate of Medical Necessity
  - CMN can be valid for up to 12 months from date patient was seen for the equipment/supplies prescribed
  - CMN must be filled out correctly, specifically identifying HCPCS being requested

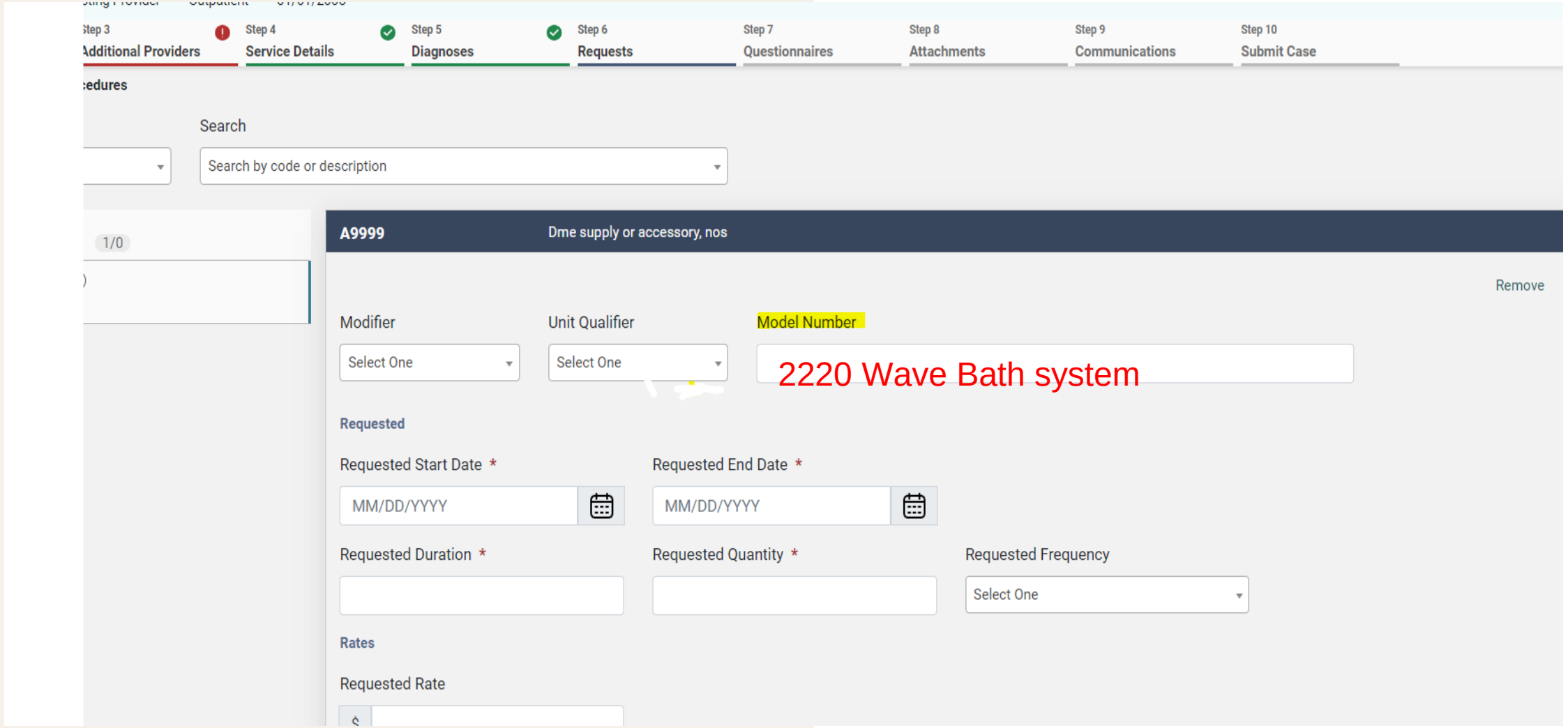
Manually Priced Items

In addition to the previously listed information, all requests for procedure codes that do not have an established allowed price on the SC DME Fee Schedule OR are indicated as Manually Priced items on the Fee Schedule must be submitted with manufacturer pricing.

113	A4418	0	$2.09	0	0	7/1/2019
114	A4419	0	$1.99	0	0	7/1/2019
115	A4420	0	M	0	1	7/1/2019
116	A4422	0	$0.13	0	0	7/1/2019
117	A4423	0	$2.14	0	0	7/1/2019
118	A4424	0	$5.48	0	0	7/1/2019

- Actual Invoice or Manufacturer Price Quote
- If submitting a screen print or web-page print out, a signature is required to certify the date, quantity, cost and description of items being billed.
- Providers are encouraged to check the Medicaid website routinely for updates to pricing, codes, and policy. Changes will be made according to Medicare updates and without prior notification.

Miscellaneous Items



Processing Timelines

Acentra Health completes requests for services expeditiously and within contractual timeframes. The review completion timeframe is measured from the date Acentra Health receives a request.

- New Request/Admission review – **15** business days
- Retrospective Reviews – **15** business days

Review Process

Administrative Requirements

- Member eligibility verified
- Provider eligibility verified
- Medicaid Guidelines applied

Nurse Review

- InterQual® or State defined criteria applied
- May pend for additional clinical information
- Approve if criteria met
- Refer to physician reviewer if documentation does not support medical necessity.

Physician Review

- The medical director, or another qualified physician reviewer will review the case against InterQual® or State defined criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Review Process – EPSDT

Early Periodic Screening, Diagnostic and Treatment

- All coverable, medically necessary services must be provided to beneficiary through the month of their 21st birthday – even if the service is not available under Healthy Connections Medicaid.
- Service/Item must be medically necessary to treat, correct, or ameliorate illnesses and conditions identified through a screening exam.
- Determination is on a case-by-case basis, taking into consideration provider recommendations, and equally effective, available alternative treatments.
- Experimental, investigational, unsafe or those treatments considered ineffective are not covered.
- Must be listed in section 1905(a) of the Social Security Act
- Acentra Health will review non-covered services/items under EPSDT rules when applicable
- Items covered under waiver programs are not benefits under EPSDT (respite, home modifications, in-home support, etc.)
- Like all other review services, any case denied can be appealed to SCDHHS.

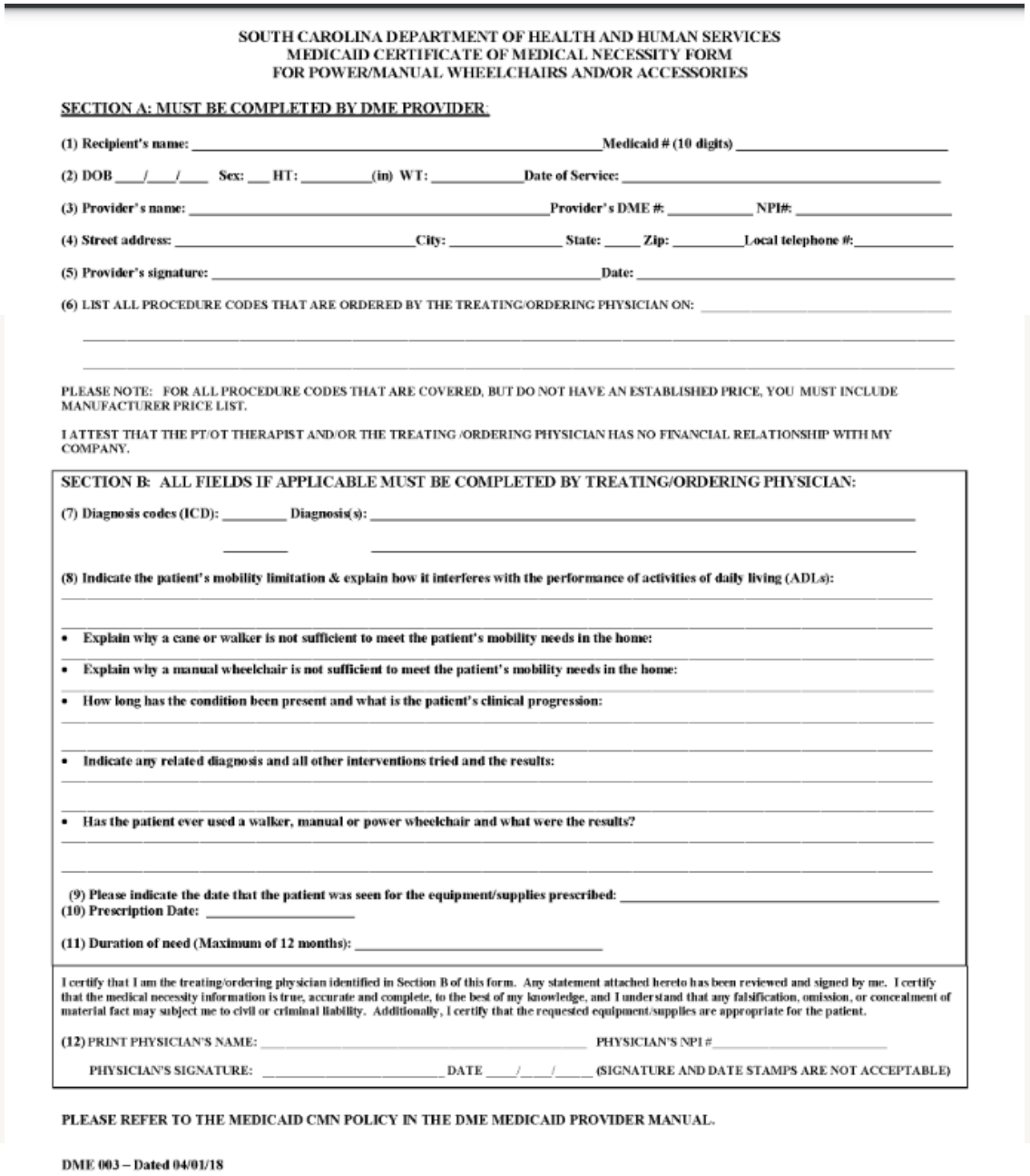
Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider number
  - Additional information or clarification is needed before a decision can be made
- Notifications are sent via fax and web portal
- A provider has 2 business days to respond to the additional information request
  - If the case contains no clinical information, the case will be administratively denied
  - If the case has insufficient clinical information and there is no response to the pend, the case will move to the physician reviewer for a determination
- If a review is administratively denied, the provider may submit a new request once they have all the necessary information

Pended Reviews

Top Reasons DME Cases are pended

- Incomplete Certificate of Medical Necessity (missing required components)
- The prescription date is more than 90 days from when the patient was seen
- The Physician signature date is more than 90 days from the date the patient was seen
- The HCPCS codes are not correct on Certificate of Medical necessity
- Invoices are not submitted for manually priced items



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

(1) Recipient's name: _____ Medicaid # (10 digits) _____

(2) DOB ___/___/___ Sex: ___ HT: _____(in) WT: _____ Date of Service: _____

(3) Provider's name: _____ Provider's DME #: _____ NPI#: _____

(4) Street address: _____ City: _____ State: _____ Zip: _____ Local telephone #: _____

(5) Provider's signature: _____ Date: _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN ON: _____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

I ATTEST THAT THE PT/OT THERAPIST AND/OR THE TREATING /ORDERING PHYSICIAN HAS NO FINANCIAL RELATIONSHIP WITH MY COMPANY.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): _____ Diagnosis(s): _____

(8) Indicate the patient's mobility limitation & explain how it interferes with the performance of activities of daily living (ADLs):

- Explain why a cane or walker is not sufficient to meet the patient's mobility needs in the home:
- Explain why a manual wheelchair is not sufficient to meet the patient's mobility needs in the home:
- How long has the condition been present and what is the patient's clinical progression:
- Indicate any related diagnosis and all other interventions tried and the results:
- Has the patient ever used a walker, manual or power wheelchair and what were the results?

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____
(10) Prescription Date: _____

(11) Duration of need (Maximum of 12 months): _____

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI # _____

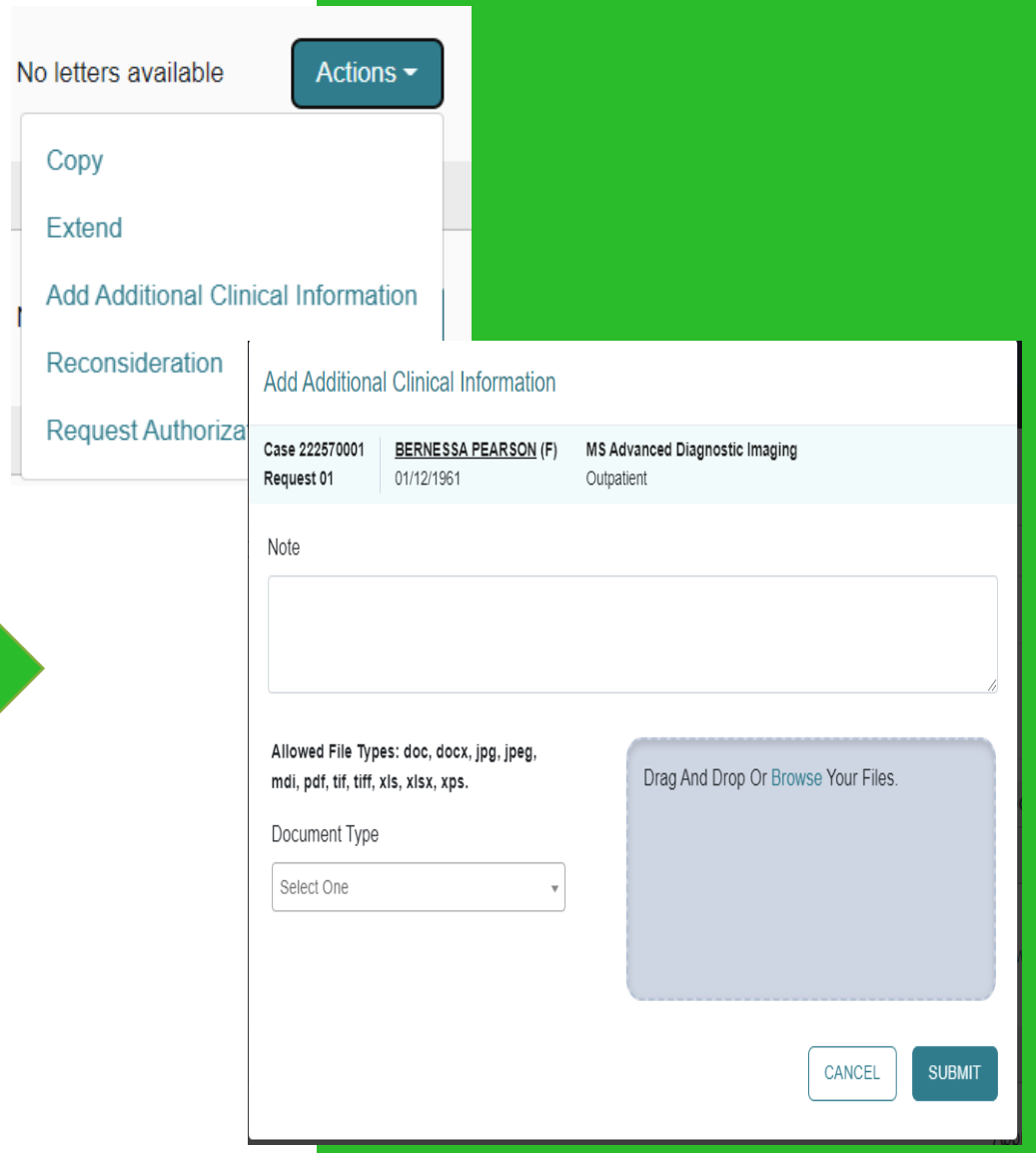
PHYSICIAN'S SIGNATURE: _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 003 – Dated 04/01/18

Responding to Pended Reviews

- If you submitted the request online thru the Portal:
  - Log into the Portal and open the pended case
  - ACTION TAB – additional Clinical Information
  - Upload the requested documents or type the information in the note section



Denials and Reconsiderations

Administrative Denial

- When any portion of the review is denied because it does not comply with Medicaid regulations
- Example: untimely, required documentation not received
- Provider may submit a new case for the service if an administrative denial is received.

Clinical Denial

- Occurs when any portion of the requested service is denied by a physician reviewer due to not meeting medical necessity
- Does not meet state Medicaid criteria with information submitted or does not meet other national evidence-based criteria

Reconsideration

- May only be requested for clinically denied cases
- Not used for Administrative Denials

Reconsiderations

- May be submitted within 30 calendar days of the **clinical** denial date
  - This is your opportunity to provide more detailed clinicals
- May be submitted via
  - Web portal *preferred
  - Fax
  - phone *least preferred (will still require additional information to be faxed)
- A clinical reviewer will review any additional information submitted. If unable to meet State approved criteria, it will be referred to the physician reviewer
- A physician reviewer – a different physician from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration
- The physician reviewer may
  - Uphold original decision (no change made)
  - Overturn the original decision (approve the case)
- If original decision is upheld, provider may appeal the decision to SCDHHS

Appeals

- If a reconsideration is upheld, an appeal may be requested. Specific instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct an internal review or Fair hearing.
- Members may request an appeal within 30 calendar days from the reconsideration determination notice:
  - online at www.scdhhs.gov/appeals,
  - Fax 803 255 8206
  - Email appeals@scdhhs.gov
  - Mail Office of Appeals and Hearings
    PO BOX 8206
    Columbia, SC 29202

Resources and Education

- SCDHHS Durable Medical Equipment Services Manual
- Provider Training Resources | SCDHHS
- SC Acentra Health website
- Acentra Health Customer Service
  - 1-855-326-5219
  - scproviderissues@kepro.com generic questions please, do not include PHI