Durable Medical Equipment (DME)

Quick Reference Guide (QRG)

DME Provider Credentialing Requirements

Contracting for durable medical equipment and supplies and/or Home Modification services have specific credentialing requirements. verifications, qualifications, licensure, based on the services being provided to the member and which program will be utilized for reimbursement to the provider, i.e., Traditional Home health (acute) or Home and Community Based Services (HCBS) program (waiver) services.

All DME and Supply Providers

Must be Medicare-certified before applying for enrollment in Texas Medicaid. All newly enrolled and re-enrolling DME providers must, as a condition of enrollment and continued participation into Texas Medicaid, obtain a surety bond that complies with Title 1, Texas Administrative Code (TAC) §352.15. The surety bond submitted to Texas Medicaid must meet the following requirements:

- A bond in the amount of no less than $50,000 must be provided for each enrolled location.
- The bond must be issued for a term of 12 months. Bonds for longer or shorter terms are not acceptable.
- The bond must be in effect on the date that the provider enrollment application is submitted to TMHP for consideration.
- Each year, providers must submit documentation that shows proof of continuation of the bond for a new 12-month term.

Audiologist and Hearing Aid Fitter

To enroll in Texas Medicaid, hearing aid professionals (physicians, audiologists, and hearing aid fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service is performed.

- Hearing aid providers are eligible to enroll as individuals and facilities.
- Audiologists are eligible to enroll as individuals and groups. Audiologists may enroll as both audiologists and as hearing aid fitters and dispensers by completing an enrollment application for each type of provider (i.e., select “Audiologist” on one application and “Hearing Aid” on the other application)

To enroll in Texas Medicaid please visit the Texas Medicaid & Healthcare Partnership (TMHP) Provider Enrollment webpage.

Qualified Rehab Professionals

A completed wheelchair seating assessment must be performed by an Assistive Technology Professional (ATP) or Qualified Rehabilitation Professional (QRP) and Physical Therapist (PT), Occupational Therapist (OT), or physician. The therapist or physician must be familiar with the member or must be the treating provider.

- Providers that render custom DME wheeled, and power mobility systems must enroll in Texas Medicaid as a specialized/custom wheeled mobility group provider and must have at least one QRP performing provider. The Certified QRP providers must enroll in Texas Medicaid as performing providers under the DME provider group.
- Payment for QRP to submit their seating assessment claims (code 97542, normally 4 units for seating assessment and 8 units for training member on device) and it must be attached to the customer wheelchair authorization for payment to be reimbursed.
- Custom Wheelchair requests are placed and authorized under the QRP as the servicing provider, the DME is placed as the requesting providers. Per TMPPM, custom wheelchairs must be set up under the QRP as they are the servicing provider. Providers must bill under the QRP.
- Standard wheelchairs are set up under the DME provider as a WC assessment performed by QRP is not required.

Pharmacy

If a pharmacy enrolled in Superior's Pharmacy Benefit Managers wishes to provide services that are not on the formulary, the pharmacy must enroll as a DME provider and obtain a separate contract with Superior for medical services. For more information, please review the TMHP Provider Enrollment webpage.

Checking Member Eligibility

- Pre - Verifying member eligibility prior to requesting authorization and rendering service is a Provider Responsibility per our manual. Frequency for recurring service- It is recommended to verify eligibility on the 1st of each month using Superior's website or by contacting Provider Services.
- Post - System is updated upon receipt of information from the state and eligibility may change (i.e. be retroactive or terminate). As a result, eligibility verification from the website does not guarantee payment. In order to maintain Medicaid eligibility a member must submit all the appropriate information to HHS during the renewal period

Change of Provider Request

The member has the right to choose his/her home health and/or DME provider and to change providers. If the member requests services through a new provider, a change of provider letter must be submitted to the Plan with the authorization request. The letter must have the following elements:

- Signed and dated by the member, parent or legal guardian
- Include previous provider's name and effective service end date
- Current provider's name and effective service start date

Payer Hierarchy

Who pays the bill?

- Commercial (Private) Insurance
- Medicaid Only/Non-Duals – Superior is primary payer
- Dual Coverage – Medicare is the Primary payer, Texas Medicaid & Healthcare Partnership (TMHP) is secondary, Superior is last payer
- Waiver – is the payor of last resort (only if member has waiver)

Benefits: Waiver (HCBS) versus Acute (Home Health)

Superior reimburses qualified members for covered durable medical equipment and pharmacy products, including medically necessary items like nebulizers and bedpans that fall under the Medicaid benefit. At times members may need medically necessary DME services that are not traditionally covered by Medicaid but can possibly be covered under the wavier programs. Adaptive aids and medical supplies are covered by the STAR+PLUS HCBS program only after the member has exhausted state plan benefits and any Third-Party Resources (TPRs), including product warranties or Medicare and Medicaid home health the member is eligible to receive. It is important to understand the benefits of these programs to understand:

- Authorizations
- Program benefits
- Expected Reimbursement

Medicaid Home Health Services (acute) benefits available under STAR Products include but are not limited to:

- DME

  - Adaptive aids
  - Medical supplies

- The STAR+PLUS HCBS is a Medicaid waiver program for members who are 21 years of age or older that offers the following:
  - Combines acute care and Long-Term Services and Support (LTSS)
  - Home modifications
  - Respite (short-term supervision)
  - Personal Assistance Services (PAS)
  - Continuum of care with a wide range of options with increased flexibility
  - Safe alternative to Nursing Facility (NF) placement.
  - Ancillary supplies and equipment
  - Durable and non-durable medical equipment not available under the Texas state plan.

- Acute vs Waiver Payments
  - Traditional DME services (Acute/Home health) will be reimbursed in accordance with the compensated schedule located in your provider participating agreement less 18%, remainder multiplied by contracted rate.
  - Wavier Adaptive aids and medical supplies (HCBS) will be reimbursed in accordance with the Manufacturer's Suggested Retail Price (MSRP).

- Prior Authorizations/ Acute Versus Waiver
  - Acute/Home Health authorizations are reviewed by the Utilization Management team.
  - Waiver (HCBS) authorizations are reviewed by the Service Coordination/ Centralized Authorization Team.

MSRP Guidelines

Correct coding requires that providers use the most specific code that matches the service being requested, based on the code's description.

- Services that do not have a unique Current Procedural Terminology (CPT) or Healthcare Common Procedure (HCPCS) procedure code may require use of a miscellaneous or unclassified procedure code. Such codes require prior authorization.
- Letter of Medical Necessity (LOMN) documenting alternative measures and alternative DME or supplies that have tried and failed to meet the member's medical needs or have been ruled out and an explanation of why they have failed or have been ruled out.
- Additional documentation requirements for miscellaneous or unclassified procedure codes include:
  - Medical records that document the medical necessity of the requested service.
  - A clear, concise description of the service.
  - The provider's fee with Manufacturer Suggested Retail Price (MSRP) or manufacturer cost invoice.
    - MSRP/Invoice date must be within (2) two years of the date of service on the claim
    - MSRP/Invoice must be clearly marked with manufacturer name.
    - Multiple Misc. code on the claim, MSRP must be clearly marked with each CPT code

For more information please visit, Superior's Clinical, Payment & Pharmacy Policies webpage.

Reconsiderations/Appeals/Correction Process

- Claim Reconsideration – A claim that has been previously adjudicated as a clean or unclean claim.
  - Unclean (deficient denied) claim - Reconsideration request that includes the missing information necessary to complete adjudication of the claim. Clean claim – Reconsideration request for which no additional information/documentation is required from the provider to re-adjudicate the claim. Can be initiated by a provider or by the health plan. By provider- Oral or in writing within timely filing.
    - Oral request - No additional information or documentation is required from the provider to re-adjudicate the claim.
    - Written request - Additional information/documentation is required to support the reconsideration (adjustment) request.
- Claim Appeal – A claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification with supporting documentation to Superior. Appeal is for anything other than medical necessity and/or any request that would require review of medical records to make a determination. All claims appeals regarding the amount reimbursed or regarding a denial for a particular service must be submitted in writing and include all necessary documentation
- Corrected Claim – A corrected claim is a resubmission of an original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claim submission required corrections.
- Timely filing – Claim Corrections, Reconsiderations and Appeals requests must be received by Superior within 120 Days from the most recent adjudication date of the claim.

Claim/Billing Tips

- Billing with authorization number is helpful when billing claim
- For Miscellaneous codes or noncovered codes provide manufacturer's MSRP
- Rejected claims must be corrected and resubmitted within 95 days of the date of service
- Rejected claims does not substantiate timely claim filing
- Confirmed appropriate modifiers billed
- Review policies to ensure criteria met for equipment or supplies
- MSRP/Invoice date must be within two years of the date of service on the claim
- MSRP/Invoice must be clearly marked with Manufacturer name
- Utilize Superior Secure Provider Portal to review for same or similar items being authorized for the member under member Dashboard. See additional information on **DME Comprehensive Training** found on Superior's Training and Manuals webpage.

For questions, please contact your local Provider Representative. To access their contact information visit, Find My Provider Representative.