

New England Medical Equipment Dealers Association (NEMED)					
Current Issues					
As of: November 2007					
Key: B=Billing, P=Policy, C=Closed					
	Issue	MassHealth Lead	Start Date	Latest Update	Action Plan (AP)/ Update(UP)
P	<p>Prior Authorizations:</p> <p>a. Consultants, at times, appear to work under their own rules.</p> <p>b. Consultants are inconsistent in what rules to apply and when.</p> <p>c. Are there filing time limits for denied/deferred PAs?</p> <p>d. Discuss process for PAs that are submitted more than 90 days after date of service. Example: CPAP is delivered to patient on 10.24.06. Documentation is received from the physician on 02.02.07 (over 90 day limit). Since providers have no control over when they will receive the required documentation from the physician, if the documentation is received past the 90-day limit, can the provider use the date the documentation was received (or physician signed) for PA purposes?</p>	Denise Egan	08/21/2007	09/06/2007	<p>a. Please provide examples.</p> <p>b. Please provide examples.</p> <p>c. Please clarify. If a PA is denied the member has the right to appeal. If a PA is deferred back to the provider, PA unit policy is to allow 30 days for provider to respond. If there is no response after 30 days, the PA unit will deny the PA.</p> <p>d. Is addressed in upcoming Transmittal letter.</p>
P	<p>Tie downs for wheelchairs – Provider gets PA under K0108 (this is an approved item for MassHealth). When the patient has Medicare primary, the tie down is denied for duplicate. We need a process to handle this situation.</p>	Lynda Scully	08/21/2007	09/06/2007	<p>Lynda had requested further clarification be submitted. Still awaiting. The clarification is necessary to answer the question.</p>
P	<p>Many insurance plans do not cover services in a Long Term Care (LTC) facility, i.e. Fallon Community Health Plan (FCHP). When a customer is in a LTC facility and is dually eligible providers obtain a letter of denial from the insurance company stating they do not cover services while the customer is in LTC. This has always been acceptable to MassHealth to adjudicate claims. There have been a few instances where providers are receiving a denial because MassHealth stated that they no longer except these letters from miscellaneous insurance companies only Medicare. (This is not a blanket letter – it is patient specific). FCHP will not give the provider a denial or EOB. What is the correct policy?</p>	Cheryl Fox	11/02/2007	11/02/2007	<p>Examples requested.</p> <p>Examples provided on 11/14/07 TCNs: 705247930A 713248132A Examples reviewed and determined to not be Global in nature. 1 is provider error as well. Examples did not have Fallon EOBs either.</p>
P	<p>Notification was sent out by MassHealth stating that providers are to send in all PAs from 7/1/07 forward for code change and price adjustments. The O2 and DME tool has not been updated to reflect the changes. Providers did as instructed and got them all back, not adjusted with a note stating that this was not in effect. The text notices have been on the runs since #1990.</p> <p>a. Are price adjustments required going back to 07/01/07 or 10/01/07?</p>	Lynda Scully	11/02/2007	11/07/2007	<p>The Transmittal letter that went out specifically stated that, "if a provider was issued a PA with the incorrect AAC + then they were to submit a paper copy of the PA and write, "requesting a price adjustment." There was only one product that the AAC + mark-up changed and that was Enteral products from 20% to 25% so that is all this message text is referring to.</p> <p>Examples provided on 11/14/07 as an attachment to an e-mail.</p>

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P	K0093 is a deleted code because it is included in the new PMD codes. However, if providers are to be paid for the K0011 and no adjustment will be done, then the K0093 should still be paid. Providers can't get the PMD codes adjustment and now can't get paid for the K0093 as well.	Lynda Scully	11/02/2007	11/07/2007	K0093 has been kept opened and will remain open until 12/31/08 and will be allowed to be used for dates prior to 01/01/07.
P	In remit 1993, providers were instructed that "any claim submitted with a date of service on or after 10/01/07 should contain the current valid ICD-9 diagnosis and procedure codes." One provider received a call from Program Review Coordinator, Laurie Devlin, informing them that the ICD-9 codes should be listed on all claims. Historically, DME providers have not had to include the ICD-9 on claims. Has there been a change in policy?	Lynda Scully	11/02/2007	11/07/2007	This has always been the policy and providers were reminded of this in DME TL-25 July 2004
P	Has there been a change in the WIC program? Providers are being told that as of Oct 1, 2007 patients who get specialty formula will need to through the Medicaid DME program and not WIC. We have a number of patients who split between WIC and our company when the request is over WIC's par level of formula. a. Please advise if the PA consultants will be ready to update a number of PA's with additional formula. b. Please confirm that the effective date is Oct 1, 2007 - the notice doesn't say that. This information is coming from the local WIC office.	Denise Egan	11/02/2007	11/08/2007	DPH is unaware of any such program change. The source of this information need be provided in order to be addressed. ADDENDUM: Karyn will forward the WIC notice to Lynda Scully and Denise Egan for follow up.
P	Please provide an organizational chart with contact information.	Lynda Scully	11/09/2007	11/14/2007	What organizational chart? ADDENDUM: Providers first point of contact is provider services. If disputing an answer, the provider can ask for a manager or contact Ingelcia Simas.
P	Are providers allowed to drop ship products to MassHealth beneficiaries? They are receiving conflicting from MA Commission for the Blind.	Lynda Scully	11/09/2007	11/14/2007	There is nothing in regulations as of today for drop shipping. Sub-chapter 4 will include language for drop shipping that will mirror Medicare.
P	When the Medicare payment and Medicaid allowable are equal, there should be no crossover payment; however several codes are paying the crossover. Providers are reimbursement the State but it is a very cumbersome process. Can the system be fixed to stop paying the crossover in these instances?	Lynda Scully	11/09/2007	11/14/2007	Examples requested. Are these changes in fees that will be part of the adjustment as the message text stated in the July 1, 2007? Examples provided on 11/14/07: 7259E6308A 7242R4063A 7259E6241A ADDENDUM: According to Lynda, if the Medicaid fee schedule is equal to Medicare, the State will pay the 20% copayment. Some fees on the old fee schedule were lower than current fees. She advised all NEMED members to check the Oxygen/DME tool on their website often.

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P	<p>9. If a MassHealth beneficiary has other insurance primary and they have maxed benefits with the primary carrier, two problems are occurring:</p> <p>a. The original claim with the primary carrier is a rental, however when the PA is obtained from MassHealth, it is approved as a sale. The primary carrier is then rebilled at a sale and denies the claim because they want it billed as a rental but MassHealth wants the primary EOB denied for the sale.</p> <p>b. Because MassHealth has approved a sale as NU (New Equipment), the PA is inaccurate because the patient has used equipment.</p> <p>c. When MH beneficiaries switch their insurance carrier in the middle of the month, it causes billing problems because of differences in coverage, payment, etc., especially for rentals. Can this practice be stopped?</p>	Lynda Scully	11/09/2007	11/14/2007	<p>a. Please provide examples. Examples needed in order to address.</p> <p>b. Please provide examples. Examples needed in order to address.</p> <p>c. Please provide examples. Examples needed in order to address.</p>
P	Direct bill claims for underpads (T4541), liners (T4535) and briefs (T4521) are being denied for "primary EOB." These codes are direct bill.	Lynda Scully	11/09/2007	11/14/2007	These are not direct bill items. All items require PA. Perhaps this is an MCO issue. Please provide examples. Examples required in order to address.
P	Can a MassHealth beneficiary be billed/charged for an item that they do not qualify for; even it is covered by MassHealth? I believe that you have said that if an item is "non-covered", the provider can bill the beneficiary. We wanted to clarify that the provider can bill the beneficiary for an item that is covered by MassHealth but they do not qualify for it.	Lynda Scully	11/09/2007	11/14/2007	This issue has nothing to do with covered vs not covered. It has to do with something if Medically Necessary or Not Medically Necessary. Please provide examples. Examples required in order to address. ADDENDUM: According to Lynda, Medicaid will pay for items that are medically necessary. The provider should submit a prior authorization, get a denial for "not medically necessary", then bill the patient.
P	Providers are receiving a 591 denial (max benefits met) for rentals. Customer Service is telling them that they see "one unit" allowed. The max should be 15 units for a cap rental.	Lynda Scully	11/09/2007	11/14/2007	This is a rule issue that has been corrected.
P	Nursing visits have been added to the new fee schedule. Are these billable codes? If so, what documentation is required for billing purposes?	Lynda Scully	11/09/2007	11/14/2007	Documentation of the actual visit. ADDENDUM: Nursing visits are covered for home infusion therapy companies. Documentation of the visit should be sent in with the claim and kept in patient file.