Agenda

• Welcome
• Policy Information and Updates
• Prior Authorization
• Interactive Voice Response System (IVRS)
• General Billing Information – Claims
• Policy Information
• Session Review
• Closing, Questions and Answers
Objectives

The information presented will enable providers to:

• Understand the DME Program changes
• Recent policy changes
• Prior Authorization
• Review options on the IVRS System
Place of Service Requirement: Effective 10/1/13 place of service requirements will be strictly enforced. Any DME item billed in a place of service other than the patient's community home will be denied. There are limited exceptions that allow the patient to receive items in a Nursing Facility, Skilled Nursing Facility, or Dialysis Treatment Center (parenteral nutrition only). See 902.2

Coverage for any DMEPOS item will be considered if the place of service is:

01 - Pharmacy
04 – Homeless Shelter
09 – Prison/Correctional Facility
12 - Home
13 – Assisted Living Facility
14 – Group Home
33 – Custodial Care Facility
54 – Intermediate Care Facility/Mentally Retarded
55 – Residential Substance Abuse Treatment Center
56 – Psychiatric Residential Treatment Center
65 – End Stage Renal Disease (ESRD) Treatment Facility (valid POS for Parenteral Nutritional Therapy ONLY)
Coverage consideration for DME items in a Skilled Nursing Facility (31) or Nursing Facility (32) is limited to the following:

- Prosthetics, orthotics, and related supplies
- Urinary incontinence supplies
- Ostomy supplies
- Surgical dressings
- Therapeutic shoes for diabetics
- Parenteral/Enteral
Durable Medical Equipment Policy Changes

(continued)

For medical review purposes, Georgia Medicaid requires that services provided or ordered are authenticated by the author with ink or electronic date and signature. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

PT/OT Evaluations –

• It is strictly against policy for a DME provider to complete or alter any portion of this evaluation, there are NO exceptions.
• The DME provider may create a template for the PT/OT, but cannot complete any portion of this document.
Manually Priced Items –

1. The invoice submitted must be the quote from the manufacturer.
2. The invoice must be unaltered (there is NO exception).
3. The price or quantity approved on the PA is the price/quantity that is to be submitted. (DO NOT submit a reasonable/customary charge or quantity other than approved.)

There will be no exceptions and any findings of alteration or inappropriate billing will be subject to recoupment and/or referral to program integrity.
The National Correct Coding Initiative (NCCI) contains two types of edits:

1. NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Technology (CPT) codes that should not be reported together for a variety of reasons. The purpose of this is to prevent improper payments when incorrect code combinations are reported.

2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.
NCCI edits are in effect. You will begin seeing denials for claims beginning 01/01/2013 for PTP and MUEs. You should become familiar with these edits to avoid unnecessary denials.

E0603/E0604 – Electric Breast Pumps can be purchased only with the NU modifier effective October 1, 2013. Breast pumps are only covered once per three years, and if the item is used for multiple pregnancies during the reasonable useful lifetime, only the kits will be covered. Coverage has been added for E0603.
E0240 – Billing Guidance added for modifiers NU and U1.

Refer to the DME SMAP for pricing of the shower/bath chair.

Refer to Appendix D for manual pricing applied to modifier U1 for other rehab toilet aids (excluding non-covered items).
Appendix X – Documentation Requirements

A new appendix has been added to provide guidance on the documentation requirements set forth by the division.
Appendix X Documentation Requirements
(Minimum Data Requirements)

1. General Information about Georgia Medicaid Coverage for DMEPOS
2. Definition of Physician as it relates to DMEPOS
3. Prescription (Order) Requirements
4. Detailed Written Orders (CMN)
5. Written Order Prior to Delivery
6. Supply Replacement/Utilization
7. Continued Need/Continued Use
8. Signature Requirements
9. Refills of Items Provided on a Recurring Basis
10. Documentation in the Patient’s Medical Record
11. Beneficiary Authorization
12. Proof of Delivery (POD)
13. Advance Beneficiary Notice (ABN)
14. Invoices (Invoice/Manually Priced Items)
15. Face-to-Face Requirement
16. Miscellaneous Documentation Issues
There must be a face-to-face encounter between the patient and the treating physician before the treating physician may certify the need for home health services.

Additionally, there must be a face-to-face encounter by a treating physician, a certified nurse-midwife, or a physician assistant under the supervision of the physician during the six-month period preceding a written order for DME.
Ordering, Prescribing, or Referring (OPR) Providers

Beginning July 1, 2013, if the National Provider Identifier (NPI) of the ordering, prescribing, or referring (OPR) provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim will not be paid.
General Billing Rules

• Bill only for **authorized** services that have actually been rendered.
• Bill directly from service records.
• Keep up with your billing -- bill on time.
• Check and print your remittance advice every Monday.
• Clean claims submitted by noon on Friday will be paid on Tuesday.
Before You Bill

• Verify the member’s Medicaid eligibility
  • Check the Georgia Medicaid Management Information System (GAMMIS)
  • Call the IVRS

• Check for PA – these can be found under the PA tab in the GAMMIS system.
Prior Authorization Request

- Providers can submit requests for prior authorization (PA) by fax, mail, or via GAMMIS.
- Additional PA information and web entry instructions are located under Provider Information/Provider Education/User Manuals on GAMMIS.
- All initial requests for PAs are reviewed by the department’s Medical Review Agent, the Georgia Medical Care Foundation (GMCF).
Prior Authorization Request

Welcome to GMCF Provider Education & Training Services

GMCF offers a variety of training resources to educate the Medicaid Provider community regarding the Prior Authorization (PA) submission process, prior authorization and waiver review processes, and other review policies and procedures. On this web page, you will find training offerings, user manuals, review reference materials and links to other training resources. GMCF has the tools to assist you in getting the job done!

Training Offerings

Click 'training offerings' to display a full list of existing and upcoming training courses. To find out more about a particular training, click the course name.

User Manuals

Click 'User Manuals' to display a list of user manuals. The user manuals provide step by step instructions for entering prior authorization requests via the web portal. To access a specific manual, click the manual name.

- Provider Workspace User Manual
- ICWP Web Entry Guide
- Attach Files to a PA Request
- Provider Instructions for Entering DMA520A Inquiries and Appeals
- CIS Frequently Asked Questions
- Children's Intervention Services Reconsiderations

This guide describes the process for submitting a reconsideration of a Children's Intervention Services PA via the web portal.
Prior Authorization Decision

Providers may view submitted prior authorization requests via GAMMIS under the Provider Workspace PA Search.
1. Click Search for Authorization Requests and Edit Requests from the Provider Workspace to open the Prior Authorization Request Search page. The Provider ID, associated with the GAMMIS login credentials, is populated by the system.
2. Enter search parameters and click **Search** to activate the search process. In the following figure, the search parameters are ‘Provider ID’ and ‘Request ID’ (blacked out), and, as a result, the search returns one request.
3. When the request ID is not used, the search may return multiple results depending on the search criteria used. The search parameters in the following example are ‘Provider ID’ and ‘Request From Date’.

**Prior Authorization Request Search**

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### IVRS Overview

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Timely Claim Submission

• Submit claims within six months of the date of service.
• Adjust claims within 90 days of paid date.
• See the Medicaid Policy and Procedures Manual, Part I, Chapter 200 for detailed information about Timely Submission.
If a claim is being submitted by mail, claims **must** be mailed to:

HP Enterprise Services  
PO BOX 105202  
Tucker, GA 30085-5202
Medicaid Provider Policy Information

• Available at GAMMIS -- www.mmis.georgia.gov

• Medicaid Provider Manuals
  • Click Provider Information tab on the home page of GAMMIS
  • Click Provider Manuals
  • Choose from the list of manuals
  • No login ID required
NOTICE: Adobe Acrobat Reader is required to view these documents. Click here to obtain the latest version of the free Adobe Reader. To save a document from this list, right-click the link and then select "Save Target As...".

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• For additional questions about policy information, contact the Provider Services Contact Center (PSCC) at 800-766-4456.

• The PSCC can also be reached by initiating a “Contact Us” inquiry on GAMMIS.
You should now be able to:

• Understand the changes in the DME Program.
• Understand general billing information.
• Understand where to find the most up to date policy information on GAMMIS.
• Understand the options of the IVRS system.
DME Program

Closing and Q & A