

Facilitating Access to Medicaid Durable Medical Equipment for Dually Eligible Beneficiaries in the Fee-for-Service System: Three State Approaches

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IN BRIEF

Beneficiaries who are dually eligible for Medicare and Medicaid often experience difficulties accessing durable medical equipment (DME), such as wheelchairs, in a timely manner. Whether Medicare or Medicaid covers a specific item may be unclear. Medicaid usually is the “payer of last resort,” which means that DME suppliers generally must obtain a Medicare denial before Medicaid will pay. For higher-cost items, waiting for a Medicare denial can create an access problem, especially for lower-income beneficiaries. To address this issue, some states, such as Illinois, California, and Connecticut, have developed procedures for provisional prior authorization from Medicaid for such items. States may supplement these procedures by posting lists of DME items that Medicare consistently denies as non-covered, and allow DME suppliers to bill Medicaid directly for these items without first billing Medicare. This can make it more likely that suppliers will provide DME to dually eligible beneficiaries in a timely way, with less confusion and uncertainty about who will pay and when.

Introduction

Dually eligible beneficiaries may face special obstacles when they try to access services, such as durable medical equipment (DME), that are covered to varying degrees by both Medicare and Medicaid. Eligibility and coverage rules that govern these services differ between the two programs in ways that can be difficult for beneficiaries, service providers, and state Medicaid program administrators to understand and manage.

A further complication is that Medicaid is usually the “payer of last resort.” Since Medicare will not adjudicate a claim until the item is delivered, a supplier may be reluctant to provide a high-priced item to a beneficiary without any assurance of payment from either program. States often operationalize this concept by requiring that suppliers first obtain a Medicare denial before Medicaid will pay for the service or, in some instances, just consider paying for it. This may cause confusion, delays for beneficiaries in receiving needed services, and administrative burdens for both suppliers and state Medicaid agencies.

DME in Managed Care. The Integrated Care Resource Center (ICRC) reviewed these issues and offered some potential solutions in an April 2014 technical assistance brief *Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment*

*Initiative.*¹ This brief outlined the problems dually eligible beneficiaries sometimes face in accessing home health and DME items and services in the fee-for-service (FFS) system. It then described some solutions that are possible in the capitated managed care environment of the financial alignment demonstrations, where a single entity is responsible for coordination and payment of these overlapping benefits.

DME in Fee-for-Service. In a FFS environment, states can take several approaches to facilitate access to DME for dually eligible beneficiaries. Several approaches were described by the federal Center for Medicaid and CHIP Services in a January 2017 Informational Bulletin *Strategies to Support Dual Eligible Beneficiaries' Access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.*² Under one strategy, some state Medicaid agencies grant provisional prior approval to DME items. This still requires the supplier to obtain a Medicare denial or a non-affirmed Medicare prior authorization request as the case may be before submitting a claim for Medicaid payment. This would give a supplier some assurance that payment would be made by either Medicare or Medicaid at some point (assuming the item is medically necessary), which could facilitate more timely access for dually eligible beneficiaries.

Provisional Prior Authorization and Lists of DME that Medicare Part B Will Not Cover. ICRC searched for examples of states that have implemented provisional prior authorization (PA) policies, supported by lists of DME that Medicare generally does not cover. Fourteen states – Alaska, California, Connecticut, Georgia, Idaho, Illinois, Indiana, Kansas, Minnesota, Nevada, New York, Ohio, Oregon, and Utah – all appear to authorize suppliers to bill Medicaid directly for DME items that Medicare generally does not cover. In order to get a better understanding of how states implement this approach, ICRC interviewed Medicaid staff in California, Connecticut, and Illinois about their state's specific billing policies and reviewed material available in relevant public documents and on each state's web site. This technical assistance tool details the DME policies in those three states and summarizes the DME policies of the other 11 states listed above in an Appendix.

DME Policies Implemented by Illinois, California, and Connecticut

California, Connecticut, and Illinois have slightly different DME billing policies. California and Illinois both implemented a feature that further facilitates the provisional PA approach. Each maintains an online list of DME items that Medicare generally denies as non-covered under Part B, but that Medicaid may cover.³ When it is clear from the list that Medicare will not cover the item, DME suppliers can submit their claims directly to Medicaid without first submitting them for a Medicare denial. In contrast, Connecticut developed a system that allows for prior authorization of DME before a Medicare denial. Following are details for each state.

Illinois' Approach to DME Delivery

The Departments of Healthcare and Family Services (HFS) and Human Services (DHS) together operate Illinois' Medicaid program. HFS administers benefits and pays for services; DHS determines eligibility.

Illinois Medicaid simplifies the adjudication and payment of DME claims for dually eligible beneficiaries by enabling providers to use:

- An online information system called Medical Electronic Data Interchange (MEDI) that lets providers verify multiple elements of a beneficiary’s eligibility, including QMB status⁴; and
- An online table for providers that specifies the services/items for which providers and suppliers can bill Medicaid directly because Medicare generally does not cover them under Part B. The table also includes other key information, such as Medicaid prior authorization requirements and the maximum quantity of DME items allowed.

Online table for DME providers. Illinois currently maintains a table on its website that indicates whether Medicare normally covers a specified DME item.⁵ The table also shows whether an item requires prior authorization, and the maximum quantity and days’ supply permitted for each. **Exhibit 1** shows an abridged version of that table.

Exhibit 1. Sample of Illinois’ Online Table of DME Coverage

HCPCS	Description	PA Required	Medicare Covered	Max Quantity	Max Days
A4213	Syringe, Sterile, 20cc or Greater, Each	No	No	15	30
A6250	Skin Sealants, Protectants, Moisturizers, Any Type	Yes	No	N/A	N/A
A7007	Large Volume Nebulizer, Disposable Unfilled, Used w/AE	No	No	2	30
E1300	Whirlpool, Over Tub Type, Portable	Yes	No	N/A	N/A

California’s Approach to DME Delivery

As in all states, the California Medicaid program (called Medi-Cal) requires that DME suppliers submit most claims for dually eligible beneficiaries to the appropriate Medicare carrier or fiscal intermediary so they can process the Medicare benefit first. However, providers are allowed to submit claims directly to Medi-Cal when any of the following criteria apply:

- Medicare does not cover the item or service;
- The beneficiary’s Medicare benefits have been exhausted; or
- Medicare has denied the claim, or the recipient is not Medicare-eligible.

List of items or services not covered by Medicare. The California Department of Health Care Services (DHCS), Medi-Cal’s parent agency, maintains a list of Healthcare Common Procedure Coding System (HCPCS) codes for items or services that can be billed directly to the state’s fiscal intermediary as “straight Medi-Cal claims” that do not have to be submitted to Medicare first.

All services or supplies billed directly to Medi-Cal must appear in the *Medicare Non-Covered Services* chart. If an item is not on the chart, a supplier must also submit a Medicare Remittance Notice (MRN) showing that the specified item(s) were denied by Medicare, when billing Medi-Cal. For complete information about

billing these claims, DHCS refers suppliers to the *Medicare Non-Covered Services: HCPCS Codes* and *Medicare Non-Covered Services: CPT-4 Codes* sections of its provider manual.⁶

Both documents include the relevant HCPCS or CPT-4 code, a brief description of each, and a column indicating “when to bill Medi-Cal directly”. The charts include the items or services that Medicare does not cover. All of the DME items are listed on the HCPCS chart. Exhibit 2 provides a sample from this document.

Exhibit 2. Sample of California’s Online Table of HCPCS codes for DME Coverage

Codes	Description	When to Bill Medi-Cal Directly
A9273, A9274, A9279, A9281, E0240 – E0245, E0273, E0625	DME	Always
E0970, E079, E1065, E1091, K0740, K0872 – K0876, K0881 – K0883, K0887 – K0889, K0892 – K0898	DME	On the UB-04, if the facility type code is other than 33 (Home Health – Outpatient) or 14, 24, 34, 44, 54, 64, 74, 75 or 89. On the CMS-1500, if the Place of Service Code is other than 12 (Home) or 99 (Other)

Connecticut’s Approach to DME Delivery

Connecticut began to operate its Medicaid program HUSKY Health through a self-insured, managed FFS model in 2012. The Connecticut Department of Social Services has contracts with Administrative Service Organizations (ASOs)⁷ for medical, behavioral, and dental health services as well as non-emergency medical transportation. Community Health Network of Connecticut (CHNCT) is the ASO that administers all medical services, including DME.

Prior authorization for DME. A 2009 Connecticut statute requires the state to consider preauthorization of a DME item before the state receives a formal denial from Medicare. According to the statute, the state cannot deny dually eligible beneficiaries access to prior authorization for new or rental DME because Medicare has not yet made a coverage determination. However, the state’s statute also prohibits it from paying a supplier without a formal Medicare denial.⁸ CHNCT is responsible for administering DME and other medical service prior authorizations. The state’s Medicaid fiscal agent (DXC Technology) handles claim processing and payments, and is responsible for assuring that a Medicare payment or denial accompanies claims for DME services that may be covered by Medicare.

Recent Federal Developments that May Facilitate Medicaid Authorization of DME for Dually Eligible Beneficiaries

Two recent developments at the federal level may make it easier for states to provide prior authorization for Medicaid DME when Medicare may also cover the item:

- **Earlier Medicare authorization of some types of power wheelchairs.** As of July 2017, a new Medicare prior authorization process is in effect nationwide for two types of power wheelchairs that may make the authorization process easier for dually eligible beneficiaries and power wheelchair providers by enabling them to get an earlier Medicare decision on those DME items.⁹

Beginning September 1, 2018, 31 additional power mobility device codes will be subject to required prior authorization. These items are currently included in the Prior Authorization of Power Mobility Devices (PMDs) Demonstration, which is scheduled to end on August 31, 2018.¹⁰

- **New incentive for states to develop lists of DME that Medicare will not cover.** A new federal law, effective January 1, 2018, limits federal matching payment for Medicaid DME that is jointly covered by Medicare to the amount Medicare would have paid, in the aggregate, for those DME items. This limitation does not apply to items of DME that Medicaid covers but Medicare does not.¹¹

To comply with this requirement, states may find it useful to compile a list of Medicaid DME that Medicare will not cover. This list could be used to facilitate access to Medicaid DME if used in the same way that Illinois and California use such lists. CGS Administrators LLC, the Durable Medical Equipment Medicare Administrative Contractor (DMAC) for Jurisdictions B and C, and Noridian, the DMAC for Jurisdictions A and D, have posted identical lists of items not covered by Medicare that may be useful for states.¹²

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The *Integrated Care Resource Center* is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for dually eligible beneficiaries. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by [Mathematica Policy Research](#) and the [Center for Health Care Strategies](#). For more information, visit www.integratedcareresourcecenter.com. For questions or comments about this technical assistance tool please email ICRC@chcs.org.

ENDNOTES

¹ Verdier, J., Streeter, S., Chelminsky, D., and Nysenbaum, J. “Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative.” Integrated Care Resource Center, April 2014. Available at: [http://www.integratedcareresourcecenter.com/PDFs/ICRC%20-%20Improving%20Coordination%20of%20HH%20and%20DME%20-%202014-29-14%20\(2\).pdf](http://www.integratedcareresourcecenter.com/PDFs/ICRC%20-%20Improving%20Coordination%20of%20HH%20and%20DME%20-%202014-29-14%20(2).pdf)

² Wachino, V. and Engelhardt, T. Center for Medicaid and CHIP Services. Informational Bulletin. “Strategies to Support Dual Eligible Beneficiaries’ Access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies” January 13, 2017. Available at: <https://www.medicare.gov/federal-policy-guidance/downloads/cib011317.pdf>.

³ DME may also be provided as part of the Medicare Part A inpatient hospital or skilled nursing facility benefit under terms and conditions that may differ from those in Part B.

⁴ Providers can use MEDI to confirm a beneficiary’s Medicaid eligibility, including their dual status. They also can verify a beneficiary’s current Medicaid managed care plan enrollment. MEDI also includes information about Medicare-Medicaid Plan enrollment for dually eligible beneficiaries covered under the state’s Financial Alignment Initiative. These features of MEDI make it easier for providers to know upfront about a beneficiary’s coverage at the time of service and the avenues available for payment.

⁵ For more information on the current (2018) IL Medicaid DME Fee Schedule see: <https://www.illinois.gov/hfs/SiteCollectionDocuments/12218DMEFeeSchedule.pdf>. Illinois’ Medicaid program also maintains a useful site for DME providers. See: <https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/DME.aspx>

⁶ California Department of Health Care Services. Provider Manuals. Available at: http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

⁷ The ASOs offer traditional health plan services, such as member and provider services, referrals to providers, utilization management (e.g., prior authorization), and grievances and appeals. Each year, Connecticut allocates a percentage of each ASO’s budget to be earned for good performance. To earn all or a portion of the performance allocation pool, an ASO must meet several performance targets.

⁸ The statute provides that: *Access to such procedure [preauthorization of the purchase or rental of new durable medical equipment and modification or repair of existing equipment] shall not be denied to a recipient on the basis that a Medicare coverage determination has not been made prior to the submission of a request for preauthorization to the commissioner. The commissioner shall not make payment for an item to a supplier of durable medical equipment on behalf of a Medicare recipient until the commissioner has received documentation establishing that a claim has been filed with, and a coverage and reimbursement decision has been rendered under, the Medicare program.* (Conn. Gen. Stat. § 17b-281a(b))

⁹ CMS. “Prior Authorization Process for Certain Durable Medical Equipment, Prosthetic, Orthotics, Supplies (DMEPOS) Items.” Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html>

¹⁰ Ibid.

¹¹ For details on how CMS will be administering this new requirement, see the January 4, 2018 State Medicaid Director Letter “Limit on Federal Financial Participation for Durable Medical Equipment in Medicaid.” Available at: <https://www.medicare.gov/federal-policy-guidance/downloads/smd18001.pdf>

¹² For more information see: <https://cgsmedicare.com/jc/pubs/news/2016/1216/cope1605.html> and <https://med.noridianmedicare.com/web/jddme/topics/noncovered-items>

Appendix. Excerpts from Medicaid DME Policies in Other States

State	DME Policy
Alaska¹	Codes published in the HCPCS coding manual that are indicated to be non-covered by Medicare are included in the Alaska Medical Assistance TPL (Third Party Liability) Avoidance file. This file is updated annually. When codes are added to the TPL Avoidance File, the claims processing system will not search for related third party information (e.g., Medicare in this example) when processing a claim with those codes. Therefore, if you bill for one of these codes, the code will be recognized as a non-covered Medicare code and you will not be required to bill Medicare. Please note that even though you will not be required to bill Medicare, it is not guaranteed that Medical Assistance will cover the item or service.
Georgia²	The following items are covered by Medicaid but not covered by Medicare and may be billed directly to Medicaid without an EOB (Explanation of Benefits) (e.g., infusion supplies).
Idaho³	Services denied or not covered by Medicare for participants who are dually eligible may be submitted electronically or on a separate paper form. These claims are not considered crossover claims. Medicaid processes these charges as the primary payer.
Indiana⁴	Claims for services not covered by Medicare must be submitted to the Indiana Health Coverage Program (IHCP) using standard claim-processing procedures and include a copy of the Medicare Remittance Advice (RA) or Explanation of Medicare Benefits (EOMB). These claims are treated like any other TPL claim. Certain services are excluded and never covered by Medicare, therefore, the IHCP can be billed first for these services, bypassing the requirement to bill Medicare first. This requirement applies to Medicare supplements, as well. Otherwise, IHCP benefits can be paid to the provider of services only after Medicare payment or denial.
Kansas⁵	When a provider receives a non-client specific blanket denial letter, the documentation should be shared with the state of Kansas TPL manager. A non-client specific blanket denial encompasses a code that is denied overall, not just for a particular member. Once reviewed, if the codes are confirmed to be non-covered, they will be added to the Third-Party Liability Non-covered Procedure Code List page on the KMAP website. Providers can reference this list and use it as a valid denial. Note: This list includes Medicare.
Minnesota⁶	Submit services that are never covered by Medicare directly to MHCP. You do not need a denial from Medicare.
Nevada⁷	It is not necessary to bill the Other Health Care if it is known that the specific service provided is not a covered benefit under OHC policy. If the recipient's OHC is Medicare and the service is not a covered Medicare service, the provider is not required to contact Medicare.
New York⁸	Claims for services not covered by Medicare should continue to be submitted directly to Medicaid as policy allows.
Ohio⁹	Services that are not covered by Medicare must be submitted to ODJFS as a regular Medicaid claim and should never be submitted as a Medicare crossover claim.

¹ Alaska Medical Assistance Program; Durable Medical Equipment, Medical Supplies, Respiratory Therapy Assessment Visits, Prosthetics, Orthotics, and Home Infusion Therapy; Provider Billing Manual; p. I-35. (Document is currently under revision.)

² Georgia Department of Community Health; Division of Medicaid; Policies and Procedures for Durable Medical Equipment Services; Revised: January 1, 2018; p. 10.

³ Idaho Department of Health & Welfare; Idaho Medicaid; Idaho MMIS Provider Handbook; General Billing Instructions; March 2, 2018; p.41.

⁴ Indiana Family & Social Services Administration; Provider Reference Module; Third Party Liability; Version 2.0; May 1, 2017; p. 14.

⁵ Kansas Department of Health and Environment; Kansas Medical Assistance Program; Fee-for-Service Provider Manual; General TPL Payment; March 2018; p. 3-5.

⁶ Minnesota Department of Human Services; Provider Manual; Provider Basics; Billing Policy (Overview); Medicare and Other Insurance; Revised: 12-03-2015.

⁷ State of Nevada; Division of Health Care Financing and Policy; Medicaid Services Manual; July 1, 2015; Section 104, p. 3.

⁸ New York State Medicaid; General Billing Guidelines; Professional; Version 2013 - 01; 6/28/2013; p. 8.

⁹ Ohio Administrative Code; 5160-1-05 (F).

Facilitating Access to Medicaid Durable Medical Equipment for Dually Eligible Beneficiaries in the Fee-for-Service System: Three State Approaches

State	DME Policy
Oregon¹⁰	<p>(1) As described in OAR 410-120-1280 (8), when an individual has both Medicare and coverage through Medicaid, providers shall make reasonable efforts to obtain payment from other resources including Medicare or other TPL.</p> <p>(2) In accordance with OAR 410-120-1280 (f), OAR 410-141-0420, and OAR 410-141-3420, behavioral health providers may bill the Division directly and may not be required to bill Medicare under the following circumstances:</p> <p>(a) For behavioral health services that are never covered by Medicare or another insurer</p>
Utah¹¹	Bill claims for non-covered Medicare services, such as non-durable medical supplies, drugs, and ICF (intermediate care facility) nursing home care provided to Medicare/Medicaid eligible members directly to Medicaid.

¹⁰ Oregon Health Authority; Health Systems Division: Medical Assistance Programs - Chapter 410; Division 172; Medicaid Payment for Behavioral Health Services; 410-172-0860; Billing for Dual Eligible Individuals.

¹¹ Utah Division of Medicaid and Health Financing; Medicaid Provider Manual; Section I: General Information; January 2018; p. 55.