Chapter 2

Provider Responsibilities

Unit 7: Ancillary Providers

In This Unit

2.7 DME/Respiratory Supplies Management Program

Overview

The DME/Respiratory Supplies Management Program requires that specific items be authorized for all Medicare Advantage program members by DMEnsion, Inc. (formerly Wright & Filippis), a nationally recognized DME company that supports Highmark's efforts by administrating utilization management, claims processing and provider support.

DME Not Requiring Authorization

DME that does not require authorization simply requires a prescription written by the ordering physician.

DME Requiring Authorization

Physicians should contact DMEnsion, Inc. (formerly Wright & Filippis) or HMS to request authorization for DME and supplies furnished through a stand-alone, Highmark Ancillary DME, prosthetics and orthotics supplier for the items listed in the Procedures/DME that Require Authorization list. The Procedures/DME that require authorization can be found on the Provider Resource Center under Administrative Reference Materials.

Authorization Requirements Vary By Product

The DME/Respiratory Supplies Management Program requires that specific items be authorized for all HMO and Medicare Advantage HMO and PPO program members by DMEnsion, Inc. (formerly Wright & Filippis), a nationally recognized DME company that supports the network's efforts by administrating utilization management, claims processing and provider support. For all other members, these items should be authorized through HMS Care Management.

What Region Am I?

For these products…	Authorization is through…
Western Region HMO Medicare Advantage HMO (Western Region Only) FreedomBlue PPO	**DMEnsion, Inc. (formerly Wright & Filippis)**
DirectBlue (group)	**HMS Care Management**
DirectBlue (individual) PreferredBlue PPOBlue EPOBlue	**No authorization required**

2.7 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products

Applicable Products

This program applies to all HMO and Medicare Advantage HMO and PPO Products.

Process

The steps listed below describe the process to obtain authorization for durable medical equipment, prosthetics, orthotics, and respiratory equipment.

Step	Action
1	The ordering physician determines whether the request must be sent to DMEnsion, Inc. (formerly Wright & Filippis).
2	If required, the ordering physician submits the request for authorization to DMEnsion, Inc. (formerly Wright & Filippis) through one of the following methods: • Submit the request through NaviNet℠. • Fax an authorization request form to 1-248-844-8614. • Mail an authorization request form to: DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460 • Call DMEnsion, Inc. (formerly Wright & Filippis) at 1-877-345-4774.
3	DMEnsion, Inc. (formerly Wright & Filippis) will review the request for benefits, eligibility, prior utilization, diagnosis, etc. • If benefits are not available, go to step 4. • If medical appropriateness cannot be determined, go to step 5. • If the request is approved, go to step 8.
4	If benefits are not available for the requested item or service, DMEnsion, Inc. (formerly Wright & Filippis) will deny the authorization request and an explanation letter from Highmark will be sent to the ordering physician and the member. Proceed to Step 9.

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2.7 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products, Continued

Process, **(continued)**

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>5</td><td>If medical appropriateness cannot be determined from the documentation provided by the ordering physician, DMEnsion, Inc. (formerly Wright & Filippis) will contact the ordering physician for additional information. This information must be returned to DMEnsion, Inc. (formerly Wright & Filippis) within 48 hours or the request may be voided and must be resubmitted. Proceed to step 6.</td></tr>
<tr><td>6</td><td>If the documentation does not substantiate the request, the authorization request is denied and an explanation from Highmark will be sent to the ordering physician and member. If medical necessity cannot be determined, the authorization request is pended and sent to the Highmark Physician Advisor Office for review. Proceed to step 7.

If the documentation substantiates the request, proceed to step 8.</td></tr>
<tr><td>7</td><td>If the Highmark Physician Advisor Office determines that the authorization
<table>
<tr><th>Is medically appropriate</th><th>Is not medically appropriate</th></tr>
<tr><td>DMEnsion, Inc. (formerly Wright & Filippis) will approve the pended authorization
Proceed to step 8</td><td>Highmark will send a denial letter to the PCP and the member and instruct DMEnsion, Inc. (formerly Wright & Filippis) to deny the pended authorization.
Proceed to step 9</td></tr>
</table></td></tr>
<tr><td>8</td><td>DMEnsion, Inc. (formerly Wright & Filippis) gives the ordering physician the appropriate HCPCS codes and the authorization number.</td></tr>
</table>

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2.7 Authorizing DME, Prosthetics, Orthotics, and Respiratory Supplies for Medicare Advantage HMO and PPO Products, Continued

Process **(continued)**

Step	Action
9	The ordering physician receives the completed authorization (approved or denied) and communicates the information to the DME, respiratory, prosthetic, or orthotic network participating supplier.
10	If the supplier believes that the equipment or supplies authorized by the ordering physician are inadequate, the supplier must contact the PCP to correct the previous authorization. The supplier may contact DMEnsion, Inc. (formerly Wright & Filippis) to make adjustments to the original request or provide additional information as long as the authorized benefits do not change. This can be done through one of the following methods: • Fax an authorization request form to 1-248-844-8614. • Call DMEnsion, Inc. (formerly Wright & Filippis) at 1-877-345-4774 (1-877-FILIPPI). The supplier must provide patient information and the reason the original order is inappropriate.

2.7 Submitting Claims for DME, Prosthetics, Orthotics, and Respiratory Equipment Authorized through DMEnsion, Inc.

Submitting Claims

The steps listed below describe the process for submitting claims.

Step	Action
1	The DME supplier submits the claim to DMEnsion, Inc. (formerly Wright & Filippis) on a CMS-1500 form by mailing it to: DMEnsion, Inc. P.O. Box 81460 Rochester Hills, MI 48308-1460
2	DMEnsion, Inc. (formerly Wright & Filippis) verifies benefits eligibility and authorization and processes the claim.
3	The check and remittance are sent to the supplier (or member, if appropriate).
4	Claim information is sent to Highmark for administrative purposes and historical record.

2.7 Pre-Service Denials for Medicare Advantage Products

Definition

A pre-service denial occurs when a physician tells a member that a specific requested service cannot be provided or continued due to lack of medical necessity or because the service is a non-covered benefit.

If the member accepts the physician's decision, this is not a pre-service denial. However, if the member continues to request the service, a pre-service denial has occurred.

Background

The Centers for Medicare & Medicaid Services (CMS) requires all contracting Medicare Advantage programs and their physicians to advise members of their right to appeal any denial of a service to which they believe they are entitled.

Policy

All Medicare Advantage HMO and Medicare Advantage PPO members have the right to appeal a pre-service denial and to be informed in a timely manner of their right to appeal an adverse decision. CMS requires that all Medicare Advantage programs must comply with pre-service denial regulations.

Pre-Service Denials After The Member Leaves The Office

If the member agrees with the physician's decision not to supply the service at the time of the visit, **but later reconsiders** and decides that he or she wants to have the service, this is a pre-service denial.

If the member calls the physician's office to communicate this disagreement, the physician's office must send the pre-service denial notice and statement of member appeal rights to the member within one business day. However, if the member calls Member Services instead, a Highmark representative will issue the pre-service denial notice and statement of member appeal rights to the member.

New Members Who Have Never Been Seen At The Office

If a Medicare Advantage HMO or PPO member, who has never been examined by the physician, telephones and requests a service, the physician has the right to ask the member to come for an office visit. If the member refuses, this does not constitute a pre-service denial because the member is not following the plan's rule that members must coordinate all non-urgent, non-emergent care. If the member is not in agreement, the physician should advise the member to contact their Member Service Department.

2.7 Medicare Advantage Home Oxygen Therapy

Introduction

Medicare Advantage HMO and PPO products provide coverage for medically necessary home oxygen therapy and the equipment necessary for the safe, effective delivery of that therapy.

Equipment Included

The equipment necessary for delivery of home oxygen therapy includes the following:

- Oxygen furnishing system
- Oxygen storage vessels
- Tubing
- Administration sets

Supplies	Codes
Stationary oxygen delivery system only ***(One code per patient per month)***	E0424 E0439 E1390
Portable oxygen delivery system only ***(One code per patient per month)***	E0431 E0434 E0443 contents payable only when stationary liquid is used with portable gaseous (E0431)
Patient owned equipment	E0425 E0430 E0435 E0440 E0441 E0442 A4615 (cannula) A4616 (tubing) E0550 (humidifier) E0555 (humidifier) E0560 (humidifier)

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2.7 Medicare Advantage Home Oxygen Therapy, Continued

Conditions For Which Coverage Is Available

Home oxygen therapy coverage is available for rented, not purchased, oxygen equipment for members with significant hypoxemia in the chronic stable state provided all of the following conditions are met:

1. The attending or consulting physician has determined that the patient suffers a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
2. The patient's blood gas levels indicate the need for oxygen therapy
3. Alternative treatment measures have been tried or considered and have been deemed clinically ineffective.

Conditions For Which Coverage Is Unavailable

Coverage for oxygen therapy for Medicare Advantage members is not available for the following conditions:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

Portable Oxygen Systems

Coverage of a portable oxygen system alone or to complement a stationary oxygen system may be allowed if the patient is mobile within the home. When submitting an authorization request, check both boxes, "portable" and "stationary."

Spare Tanks Or Emergency Inhalators

Spare tanks of oxygen or emergency oxygen inhalators are considered not medically necessary since these items are precautionary and not therapeutic in nature.

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2.7 Medicare Advantage Home Oxygen Therapy, Continued

Blood Oxygen Determinations

Initial orders for oxygen therapy must also include the results of a blood gas study, usually a measurement of the partial pressure of oxygen (PO_2) in arterial blood. **The study must be performed within 30 days before the date of service.**

The study should be performed under one of the following circumstances:

- Ordered and evaluated by the attending or consulting physician
- Ordered and evaluated by the attending physician and performed under his or her supervision
- Performed by a qualified provider or supplier of laboratory services

Note: Medicare does not recognize DME suppliers as qualified to provide or supply blood oxygen determinations.

Conditions Of Blood Gas Studies

The conditions under which the blood gas study was performed must be specified in writing and submitted on the *Certificate of Medical Necessity* (CMN) form. Examples of this documentation may include the following:

- At rest
- While sleeping
- While exercising
- On room air
- On oxygen

Note: If the study is performed while the patient is receiving oxygen, indicate the following:

- Amount
- Body position during testing
- Additional information required for interpretation

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2.7 Medicare Advantage Home Oxygen Therapy, Continued

Blood Gas Level Criteria

The table below describes three groups of blood gas levels for which coverage is provided.

Group	Blood gas level criteria
Group 1 *Medically necessary*	Arterial PO_2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken at rest. OR Arterial PO_2 is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken during sleep for a patient who demonstrates arterial PO_2 at or above 56 mm Hg or arterial oxygen saturation at or above 89% while awake. OR A greater than normal fall in oxygen level during sleep (arterial PO_2 decreases more than 10 mm Hg, or arterial oxygen saturation decreases more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis). OR Arterial PO_2 is at or below 55 mm Hg or arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates arterial PO_2 at or above 56 mm Hg or arterial oxygen saturation at or above 89%, during the day while at rest. In this case, supplemental oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

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2.7 Medicare Advantage Home Oxygen Therapy, Continued

Blood Gas Level Criteria, **continued**

Group	Blood gas level criteria
Group 2 *Medically necessary*	Arterial PO_2 is 56 to 59 mm Hg or arterial blood oxygen saturation is 89% if any of the following are documented: • Dependent edema suggesting congestive heart failure • Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave is greater than 3 mm in Standard Leads II, III, or AVF) • Erythrocythemia with a hematocrit greater than 56%
Group 3 ***Not*** *medically necessary*	Home use of oxygen is not medically necessary for members with PO_2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

Additional Studies

Retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity when a patient's initial certification for oxygen is approved based on one of the following criteria:

- Arterial PO_2 was 56 mm Hg or greater
- Oxygen saturation was 89% or greater

Certificate Of Medical Necessity

A *Certificate of Medical Necessity* (CMN) form for home oxygen is necessary for the following:

- Initial certification
- Recertification
- Changes in the oxygen prescription

The CMN must be completed, signed, and dated by the ordering physician.

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2.7 Medicare Advantage Home Oxygen Therapy, Continued

Obtaining Authorization

DMEnsion, Inc. (formerly Wright & Filippis) must authorize all home oxygen therapy for Medicare Advantage members. Follow the steps listed below to obtain authorization.

Step	Action
1	The physician enters a request for oxygen into NaviNet[SM]. The physician should also fax a CMN form to DMEnsion, Inc. at 1-248-844-8614 at the same time.
2	The electronically submitted request is automatically sent to DMEnsion, Inc. (formerly Wright & Filippis). Fax paper referral forms to DMEnsion, Inc. at 1-248-844-8614.
3	If the physician has not included a CMN form, DMEnsion, Inc. will send or fax a CMN form to the physician for completion.
4	Physician returns completed CMN form to DMEnsion, Inc.
5	DMEnsion, Inc. sends an authorization approval through ROAR or by fax.
6	The physician sends the approved request to a DME supplier.
7	The DME supplier provides services to the patient.

Recertification

Recertification must include the results of a recently performed arterial blood gas (ABG) or oximetry test; and it is required one to three months after initial certification under the following circumstances:

- If the patient's arterial PO_2 was 56 mm HG or greater at the initial certification
- If the patient's oxygen saturation was 89% or greater at the initial certification
- If the physician initially estimated that oxygen was needed for one to three months

Note: Once recertification establishes medical necessity for continued therapy, subsequent recertification is not required except when there is a change in the oxygen prescription or the attending physician.

2.7 Diabetic Testing Devices for Medicare Advantage HMO and PPO Members

Changes Effective January 1, 2006

Medicare Advantage HMO and PPO products provide coverage for medically necessary diabetic testing devices including glucometers, test strips and lancets effective January 1, 2006. Insulin pens and insulin pumps are also being covered under DME. Insulin and syringes will not be covered as DME, but will be covered under the Medicare Part D Prescription Drug Benefit.

Purchasing Diabetic Testing Devices

Members are now able to purchase these items from any participating, in-network DME vendor with applicable member cost-sharing under Medicare Advantage.

Part B Drugs are covered in full after a copayment when they are obtained from an in-network specialty pharmacy, DME vendor, or furnished in a physician's office. Any out of network supplies, are subject to additional copayments and coinsurance.

Although FreedomBlue PPO members have out-of network benefits, those members who elect to go out-of-network to purchase DME supplies will incur additional out-of-pocket expenses. Please review the patient's specific benefit design to determine possible authorization requirements and/or coinsurance amounts and maximum annual coinsurance amounts.

Prescriptions For Multiple, Daily Diabetic Testing

If a patient is instructed to test multiple times in the same day for diabetes, treatment prescriptions for DME diabetic supplies should be written to clearly state the correct frequency of testing (Ex. To be tested three times daily). This will ensure that the correct amount of supplies are ordered and submitted for DME coverage under a Medicare Advantage product.

Many of the in-network DME vendors can supply increased supplies in a timely manner. If a patient requires additional supplies the treating physician will need to provide the patient with a new prescription detailing the testing frequency. After receiving the new prescription, the patient will need to contact the DME vendor to indicate that their testing needs have increased and that their physician wrote a new prescription detailing the change.

Mail Order Diabetic Testing Supplies

Members are still able to order 90-day supplies of diabetic supplies via mail order. The physician must write the prescription to reflect the long term supply so that the member is able to submit the prescription to the mail order DME vendor and receive accurate long term supplies.

For More Information

If you have specific questions about diabetic testing devices for Medicare Advantage members, please contact Provider Service.

2.7 Medicare Prescription Drug Coverage under Medicare Advantage

Prescription Drug Coverage

Medicare Advantage HMO and PPO products provide Part B prescription drug coverage (MA-only plans). Some Medicare Advantage plans may also include Medicare Part D Prescription Drug Coverage benefits (MA-PD plans). Effective January 1, 2006, Medicare Advantage members can obtain the following Part B drugs from the following providers/suppliers:

- oral medication for cancer from specialty pharmacies including Medmark and
- nebulizer solution from approved Durable Medical Equipment (DME) vendors.

Medicare Advantage HMO and PPO members are **not** able to purchase any Part B drugs, including those listed above, at a retail pharmacy.

Medicare Advantage HMO and PPO members can obtain oral medication for cancer from a specialty pharmacy when it is covered under their Part D benefit, but are not required to do so.

Coverage Levels for In And Out Of Network Purchases

Part B drugs are covered in full after a co-payment when they are obtained from an in-network specialty pharmacy or a DME vendor.

If FreedomBlue PPO members purchase these drugs at an out-of-network specialty pharmacy or DME vendor, in addition to a co-payment, they are responsible for 20-30% coinsurance on the lesser of the out-of-network charge or network allowed amount as well as any difference between the out-of-network charge and network amount. Highmark's Western Region Medicare Advantage HMO product does not have an out-of network benefit.

Members Can Buy Supplies From A Listing Of Vendors And Pharmacies

There are several network specialty pharmacies and DME vendors from which members can choose. A listing of specialty pharmacy providers and DME vendors are now available on NaviNet[SM] and via www.highmark.com.

For More Information

If you have specific questions about changes to the way Medicare Advantage members can obtain certain Part B drugs, please contact Provider Service.

2.7 DME Supplies Provided in the Physician Office

Simple DME Supplies Can Be Provided In The Office Setting

Minor DME items, prosthetics, orthotics, and supplies incidental to a physician or facility that do not require authorization can be furnished to members for their convenience in the physician office setting.

What Region Am I?

Applicable Products

The supplies listed below can be provided in the office setting for Medicare Advantage HMO and PPO members as well as other Highmark managed care members enrolled in many Highmark Blue Shield products.

Submit A Claim For The Appropriate Charge

Under no circumstances should a member be charged for such items or supplies. Include the charge for the item/supply on a claim and submit to Highmark following normal billing protocols.

Eligible Supplies/Items

Following is a list of those items that can be supplied to members in the office setting and billed to Highmark for reimbursement at fee-for-service. *These supply items do not require authorization.*

Item	Code
Crutches, underarm, wood, adjustable or fixed, pair with pads, tips and handgrips	E0112
Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips	E0114
Cervical, Flexible, non-adjustable (foam collar)	L0120
Knee orthosis, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment	L1830
Plastazote sandal-each	L3265
Wrist hand Orthosis, wrist extension control cock-up, non molded, prefabricated, includes fitting and adjustment	L3908
Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel) prefabricated, includes fitting and adjustment	L4350
Pneumatic knee splint, prefabricated, includes fitting and adjustment	L4380
Peak Expiratory Flow Rate Meter, Hand Held (Effective 03/01/06)	A4614
Spacer, Bag or Reservoir, with or without mask, for use with metered dose inhaler (Effective 03/01/06)	A4627

IMPORTANT! All Other DME And Supplies

Requests for all other DME, prosthetic and orthotic supplies must be directed to a network DME, prosthetic and orthotic provider. Search in NaviNet[SM] for eligible providers within each managed care product.