EmblemHealth

Durable Medical Equipment

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Chapter Summary

This program describes our procedure for the prescription of durable medical equipment (DME). DME coverage is subject to the member's benefit plan. Members may be responsible for paying a portion of the DME's cost in the form of a copay/coinsurance and/or deductible. The DME provider will notify the member when copays/coinsurance and/or deductibles are due.

Preauthorization may be needed before certain services can be rendered or equipment supplied. Depending on which networks members access and who has financial risk for their care, preauthorization requests are evaluated by either the DME vendor (eviCore), EmblemHealth, or a Managing Entity. For the list of Healthcare Common Procedure Coding System (HCPCS) codes requiring preauthorization, refer to **Clinical Corner**.

DME must be ordered from a contracted DME provider. Most DME providers will work with your office to complete the preauthorization request (including the applicable forms). To locate an appropriate DME provider in your area, visit **emblemhealth.com/find-a-doctor**.

Definitions

Customized DME - Any prosthetic, orthotic, or equipment that must be designed and built to meet the specific needs of a patient (e.g., power wheelchairs, braces, prosthetic limbs).

Rental DME - Any equipment intended for short-term home use (e.g., oxygen and its delivery devices, hospital beds,wheelchairs and scooters). In general, Medicare coverage rules apply.

Preauthorization Procedures For Members Managed By eviCore

eviCore performs preauthorization services for Health Insurance Plan of Greater New York (HIP), EmblemHealth Insurance Company (formerly HIP Insurance Company of New York (HIPIC)), and Bridge Program members. See the:

- **2024 Summary of Companies, Lines of Business, Networks & Benefit Plans**
- **2023 Summary of Companies, Lines of Business, Networks and Benefit Plans**

Exception: Health care professionals treating members whose care is managed by HealthCare Partners and Montefiore CMO are required to contact those Managing Entities to verify coverage and procedures.

How to Request Preauthorization

To avoid unnecessary delays and denials, please use this **DME Preauthorization Request Checklist** to see the minimum information required to process a preauthorization request. Complete the appropriate **form** and submit to eviCore with supporting clinical documents in one of three ways:

1. Online at: **evicore.com/provider**
2. By fax: Fax the applicable completed request form to 866-663-7740.
3. By phone: Call **866-417-2345**, option 3 for HIP, then option 4. Representatives are available Monday through Friday, from 7 a.m. to 7 p.m. eviCore is closed New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday after Thanksgiving, and Christmas Day.
4. Clinical information to submit with request form:
   - Current physician's order/script
   - Current detailed invoice listing all requested equipment
   - Current certificate or letter of medical necessity
   - Patient's medical records with details on current clinical information in support of the request such as:
     - Admitting diagnosis, if DME request is part of a discharge plan
     - Patient history and physical
     - Progress notes
     - Medication list
     - Wound or incision/location

Preauthorization Notification

Notifications to members and providers are both written and verbal.

Notification to COMMERCIAL AND MEDICAID MEMBERS

Written notification in the form of a letter is:

- Faxed to both the requesting physician and DME supplier
- Mailed to the member via standard U.S. mail
- Available for review on eviCore's portal

Verbal notification:

- Verbal outreach to members and providers occurs for all determinations.

Verbal and written notification requirements are made within regulatory **time frames**.

Notification to MEDICARE MEMBERS

Written notification in the form of a letter is:

- Faxed to both the requesting physician and DME supplier
- Mailed to the member via standard U.S. mail
- ·Available for review on eviCore's portal

After the Unable to Approve process is complete, written notification in the form of a denial letter is:

- Faxed to both the referring physician and DME supplier
- Mailed to the member via standard U.S. mail
- Available for review on eviCore's portal.

Verbal notification for expedited requests:

- Verbal outreach to members and providers occurs for all expedited determinations.

Determinations are made within two (2) business days for a routine request and within 72 hours for an urgent request.

Medical Necessity Criteria

Medicare:

- Medicare Benefit Policy Manual
- National and Local Coverage Determination
- MCG Criteria (formerly known as Milliman Care Guidelines)
- eviCore Clinical Guidelines for PAP devices and supplies

Medicaid:

- New York State Medicaid Program Criteria
- Durable Medical Equipment, Orthotics, Prosthetics, and Supplies Procedure Code and Coverage Guidelines
- eviCore Clinical Guidelines for PAP devices and supplies
- MCG Criteria (formerly known as Milliman Care Guidelines)

Commercial:

- MCG Criteria (formerly known as Milliman Care Guidelines)
- eviCore Clinical Guidelines for PAP devices and supplies

Retrospective Reviews:

eviCore performs retrospective reviews of medical necessity for post-acute care. Submit requests within 14 calendar days from the date the initial service was rendered; however there is no time limit for retrospective requests.

Sleep Program/CPAP Compliance – Program Therapy Support:

CPAP compliance data is monitored for EmblemHealth/HIP Commercial, Medicare, and Medicaid members by eviCore. Please visit evicore.com for additional program information and reference guides.

Reconsideration And Appeals Process

Cases that do not meet medical necessity may be reconsidered (have a peer-to-peer discussion) or appealed.

Reconsideration Process (Commercial and Medicaid only)

A reconsideration is a post-denial, pre-appeal opportunity to provide additional clinical information. Reconsideration must be requested within 14 days of the initial denial date. Peer-to-peer (P2P) review requests can be made verbally or in writing. P2P is conducted with the referring physician and one of eviCore's Medical Directors. P2P results in either a reversal or an uphold of the original decision. The requestor and the member are notified via mail and fax.

Appeals Process (Medicare, Medicaid, and Commercial)

eviCore handles first-level Commercial and Medicaid appeals. Medicaid or Commercial members may request an appeal by following the instructions in the denial letter. Providers should submit appeal requests to eviCore via:

- Phone at 800-835-7064, Monday through Friday, 8 a.m. - 6 p.m.
- Fax to 866-699-8128

EmblemHealth handles Medicare appeals. Medicare members may request an appeal by following the instructions in the denial letter. Providers should follow the process in the Provider Manual's **Dispute Resolution for Medicare Plans** chapter..

Turnaround time after an appeal has been requested by the member is as follows:

- Expedited: up to 72 hours
- Standard: up to 30 days

Preauthorization Procedures For Members Managed By EmblemHealth

The following rules apply to EmblemHealth Plan, Inc. (formerly GHI) members. See the:

- **2024 Summary of Companies, Lines of Business, Networks and Benefit Plans**
- **2023 Summary of Companies, Lines of Business, Networks and Benefit Plans**

Special EmblemHealth Plan, Inc. Member Benefits

Diabetic Medications

For information regarding diabetic medications for EmblemHealth Plan, Inc. members, please refer to the **Pharmacy Services** chapter.

Blood Glucose Meters and Testing Supplies – EmblemHealth Medicare PPO and Medicare Prescription Drug Plan Members

EmblemHealth only covers blood glucose meters and testing supplies for Abbott Diabetes Care products.

Patients who need a change in their testing frequency or the type of meter or supplies used will need a new prescription. Patients new to our plans may obtain a prescribed Abbott meter at no cost by calling **888-522-5226** or by visiting the Abbott Diabetes Care website: **AbbottDiabetesCare.com**.

For questions, product support, or meter replacement, please direct your EmblemHealth patients to call Abbott Diabetes Care Product Support at **888-522-5226** or to go online at **AbbottDiabetesCare.com** for assistance.

Members can receive mail order glucometers, Continuous Glucose Monitors (CGMs), and testing supplies from Better Living Now, with their doctor's prescription. Orders can be placed by phone at **800-854-5729** or **online**.

Blood Glucose Meters and Testing Supplies – All Other EmblemHealth Plan, Inc. Members

For all other EmblemHealth Plan, Inc. members, medical/surgical supplies are covered as specified under the medical benefit with the participating vendor.

How to Request Preauthorization for EmblemHealth Plan, Inc. Members

Preauthorization for the NYC membership is managed by Anthem Blue Cross and Blue Shield (formerly known as Empire BlueCross BlueShield). Preauthorization is required for DME services costing more than $2,000 per unit/item.

See the **Who to Contact for Preauthorization** chart in the **Directory** chapter for instructions on submitting preauthorization request for EmblemHealth Plan, Inc. members. See the:

- **2024 Summary of Companies, Lines of Business, Networks and Benefit Plans**
- **2023 Summary of Companies, Lines of Business, Networks and Benefit Plans**

The preauthorization request should include:

1. Request for prior approval
2. Written prescription
3. Name of DME vendor
4. Applicable Certificate of Medical Necessity (CMN) form(s)

Written Prescription

To initiate coverage of DME, the provider must issue a prescription, or other written order on personalized stationery, which includes:

- Member's name and full address
- Provider's signature
- Date the provider signed the prescription or order
- Description of the items needed
- Start date of the order (if appropriate)
- Diagnosis
- A realistic estimate of the total length of time the equipment will be needed (in months or years)

Electronic requests for DME preauthorization must be accompanied by a fax containing the written prescription and any applicable CMN forms. All paperwork must be signed by the provider. Signature stamps are not acceptable.

Certificate of Medical Necessity

In addition to the written prescription, providers should fill out a Certificate of Medical Necessity (CMN) form when requesting customized equipment or oxygen therapy or when providing clinical information. Providers, not DME suppliers, are responsible for properly and conscientiously completing the CMN form for all prescribed DME items.

Filling out the CMN form involves:

- Certifying the patient's need. The treating physician must certify in writing the patient's medical need for equipment and attest the patient meets the criteria for medical devices and/or equipment.
- Issuing a plan of care. The treating physician must issue a plan of care for the patient that specifies:
  - The type of medical devices, equipment, and/or services to be provided
  - The nature and frequency of these services

Note: For home oxygen therapy procedures, current blood gas levels and oxygen saturation levels must be noted in the CMN form.

EmblemHealth accepts any of the standard CMN forms provided by the Centers for Medicare & Medicaid Services (CMS). These forms can be found on the forms section of the **CMS website**. Providers must complete Section B of the forms accurately and clearly and transfer adequate notation into the patient's chart to corroborate the answers supplied on the CMN form.

EmblemHealth's DME preauthorization procedure is consistent with the CMS/Local Medicare Coverage Guidelines for all lines of business. These guidelines are readily accessible at **cms.gov** and Anthem Medicare.

Preauthorization Issuance

EmblemHealth's Care Management program reviews each preauthorization request to determine the member's eligibility to receive the benefit and the medical necessity for the prescribed equipment or supply.

After Hours Preauthorization

In the event there is an urgent request for equipment requiring preauthorization that needs to be ordered on a weekend (5 p.m. Friday through 8 a.m. Monday) or on a holiday (5 p.m. the evening before through 8 a.m. the morning after), the provider should contact our emergency 24-hour prior approval line at **866-447-9717**. All non-urgent requests will be processed on the next business day.

Discharge Planning

Notify EmblemHealth of the need for DME as soon as possible. Delays in ordering DME may compromise or delay a discharge from the hospital or rehabilitation center. Only in emergency situations should EmblemHealth be contacted on the day of discharge for DME.

Record Keeping and Claims Submission

DME suppliers who submit bills to EmblemHealth are required to keep the provider's original written order or prescription in their files. Providers are required to document the medical need for and utilization of DME items in the member's chart and to ensure information about the member's medical condition is correct. In the event of a medical audit, EmblemHealth may require copies of relevant portions of the patient's chart to establish the existence of medical need as indicated in the CMN form submitted with the preauthorization request.