



MVPSM
HEALTH CARE

**MVP Health Care
DME and O & P Coverage and Purchasing Guidelines**

January 2011

“Take on Life and Live Well”

The DME and O & P Coverage and Purchasing Guidelines apply to all MVP participating DME, Orthotics, prosthetics and specialty vendors only. Physicians, podiatrists, chiropractors, physical therapists and occupational therapists must refer to the MVP Health Care Provider Resource Manual for DMEPOS information and guidelines.

Effective January 1, 2011, there will be a single point of contact for DMEPOS prior authorization reviews for all lines of business. Items and/or services requiring prior authorization must be faxed to the DME Unit at fax number 1-888-452-5947. Supporting medical documentation must accompany each request to avoid a delay of determinations. Phone requests will be taken for urgent care determinations only. The “DME Prior Authorization Request Form” is available on the MVP website under the Provider section/References/Durable Medical Equipment.

Depending on the member’s individual plan and coverage, some items and/or services may or may not be covered. It is imperative that providers verify member eligibility and benefits before requesting or providing services. The “DME Prior Authorization Code List” does not guarantee payment. Log onto www.mvphealthcare.com or call: Schenectady Member Services, 1-888-687-6277 for members ID’s beginning with an “8”. For members ID’s beginning with an *alpha character*, contact Provider Services at, 1-800-999-3920.

For specific questions regarding DMEPOS items and services you may contact the DME Unit directly at 1-800-452-6966. Refer to the general MVP Health Care Durable Medical Equipment Benefit Interpretation, available on the MVP Website, under Providers, for more details.

DME staff is available 24 hours, 7 days a week, by calling 1-800-452-6966.

I. General Guidelines

Only DMEPOS items and services requiring prior authorization are listed on the “DME Prior Authorization Code List”, with and without descriptions. The list is updated quarterly and is located on the MVP Health Care Website in the Provider section, under References.

<https://www.mvphealthcare.com/provider/dme.html>

If prior authorization was not obtained for the required medically necessary items/services, the member may not be billed by the provider.

Providers may NOT expect members to pay “up front” for items or services.

MVP prefers that providers be accredited by an applicable licensing body. While this is not a requirement of participation at this time, it may be so in the future. It is important for providers to submit claims with the appropriate modifier or reimbursement may be delayed or possibly denied for “no modifier”.

- A. MVP reserves the right to determine the appropriate servicing provider based on the member's coordination of care.
- B. Rental items that appear on the "DME Prior Authorization Code List" require an authorization through MVP's DME Unit. MVP reserves the right to decide if an item will be rented or purchased based on acute or chronic conditions. It is also at MVP's discretion to rent to the purchase price. All supplies associated with rental equipment are included in the rental cost.
- C. For authorized items that have a rental price, MVP will calculate the purchase price based on 13 months rental. (Example: \$100 per month, purchase price = \$1,300. Payment for the rental months will be subtracted from the purchase price of \$1,300.)
- D. MVP's contracted rates are for new equipment only. MVP does not authorize used equipment for purchase.
- E. Delivery charges, including shipping and handling, are considered part of the purchase or rental costs. *Provider may not bill MVP or the Member for these charges.*
- F. If MVP is to make payment as the secondary plan, MVP's protocols still apply. However, in the event the provider receives approval from the primary insurer prior to rendering of services, MVP will not deny a claim for the services on the basis that no prior approval was received from MVP. This does not preclude MVP from determining that the services were not medically necessary or otherwise not covered under the policy. Provider must bill MVP as secondary to ensure that MVP members are not billed inappropriately.
- G. If for some reason provider is unable to contact MVP for pre-authorization, provider agrees to accommodate member and dispense item(s) in the medical interest of the member and contact the DME Unit as soon as possible to handle the authorization, on a case-by-case basis.
- H. MVP covers medically necessary STANDARD equipment only. Requests for upgraded or non-standard equipment must be reviewed for medical necessity prior to dispensing. If a member prefers to purchase an enhanced item, the member will be financially responsible for the difference in cost between the contracted price for the standard item and the enhanced item, in addition to the co-payment. Provider must maintain a signed waiver on file, available to MVP upon request.
- I. Provider will develop and submit a written plan of correction for problems and concerns identified by MVP within thirty (30) days of notification.
- J. Provider agrees to honor all manufacturers' warranties.
- K. MVP will reimburse for one (1) month's rental fee for temporary equipment while patient-owned equipment is being repaired.
- L. Labor and parts require prior authorization of the DME Unit. Reimbursement will be based on your contracted rate with MVP.

- M. Codes billed with maintenance and servicing modifier (MS) may be submitted for payment for Medicare Primary members only. When billing the MS modifier, prior authorization is required for those codes on the DME Prior Authorization Code List. Claims must be submitted with a Medicare EOB attached.

II. Procedure for dispensing DME and O & P:

- A. Provider verifies eligibility and benefits.
- B. If provider chooses to decline a referral, a call to the DME Unit is required. The DME staff will follow-up with the physician and member. Provider must participate in coordination of care when unable to provide the requested item or services.
- C. Upon completion of medical review by MVP, a determination will be communicated both verbally and in writing to the member, physician and the provider.
- D. MVP has the sole right to make approval or denial determinations for MVP members.
- E. All requests for pre-authorization must be accompanied by medical justification, physician's orders and a description of the requested item(s) or service, including HCPCS codes. Provider must supply MVP with a copy of the physician prescription as needed, if receiving phone authorization. Providers will be reimbursed *only* for the approved codes as indicated at the time of the authorization.
- F. Hospital Discharges: Equipment required to facilitate a member's discharge from the hospital is considered an "urgent" request and provider is expected to provide services within four (4) hours. Provider and/or hospital discharge planners are required to call the DME Unit initially, to assure prompt care. Medical information may be faxed after the fact. (See telephone and fax numbers at the beginning of this document)
- G. MVP will not reimburse for items dispensed by facilities or physician's offices where the DME provider maintains a "DME Closet", unless those items are prior authorized by MVP.
- H. Provider agrees to maintain twenty-four (24) hour service availability and guarantee response time within twenty-four (24) hours for delivery of equipment or supplies. A guaranteed response time of within four (4) hours applies to urgent requests, respiratory services or discharges from the hospital.
- I. MVP Health Care follows MVP medical policy and benefit coverage guidelines. In the absence of policy, MVP follows Medicare Affiliated Contractors' (MAC) rules in the following order: CMS – Centers for Medicare and Medicaid, NHIC, Corp. – National Heritage Insurance Company – Medicare's DME administrative contractor for Medicare Region A (DMERC), maintains supplier manuals, DME

list serves, outreach and education and Medicaid – MVP follows the Medicaid DME Provider Manual for MVP Option members.

- J. Provider is required to collect co-payments and/or co-insurance.
- K. MVP does not “backdate” authorizations for items where prior authorization was not obtained. Members are not held financially responsible under this circumstance.