Scenario:
1. Like for Pharmacy, if a DME provider (contracted with a health plan) provides supplies prescribed by a physician who is not contracted with a health plan, will the health plans still pay for the items prescribed? As long as facility has contract, if DME provider is INN, the it will be paid as INN

Enrollment:
1. Will the MCO Plans have specific portals for eligibility? Eligibility through state portal
   When will this be available for new referrals and existing patients? NCTracks.

Documentation:
1. Will any documentation and medical coverage criteria requirements change from payer to payer? All PHPs using standard protocols - Changes not expected.
2. O2 testing? – We will Follow State Guidance
   Is the Medicaid NC CMN (Cert of Medical Necessity ) form still required for all plans? For UHC- The form is posted online, but not required. A notification made to our online portal and clinical provided should contain all needed information.

3. Will items covered only under the pharmacy benefit currently be available to be paid under the DME benefit. (i.e. Continuous Glucose Monitors)? For Pharmacy we will pay as the state pays. For example: If an item is only covered under the pharmacy benefit and not DME with NC Medicaid FFS, then the same coverage would apply with UHC. DME: Use Chapter 4 page 42 for what is covered. Example of items covered under the pharmacy benefit (in alignment with NC Preferred Drug List):
   - Diabetic supplies (AccuChek products are preferred)
     - Test strips
     - Lancets
     - Lancing devices
     - Control solution
   - Continuous Glucose Monitors (Dexcom and FreeStyle Libre 2 are preferred)
     - Receivers / Readers
     - Sensors

3. How will MCOs handle exceeding quantity limits? Our DME policy is consistent with state. Will deny if over limit unless EPSDT or other SCA exceptions.

4. Will managed care plans be paying for items that are not currently paid under FFS? (i.e. Wound Care) Similar to #2 above.
5. How will MCOs handle non-covered supplies? Typically denied, except EPSDT/med nec.

**Authorizations:**
1. Is there reciprocity for authorizations between health plans when a beneficiary switches from one plan to another? Specifically concerning the DME industry because of rentals and other care that is continual. i.e., Does PA follow? UHC model built around PA following member transition (In & out). PAs honored for life of original approval period/end date.

2. How are the Health Plans handling retroactive eligibility? Managed via State/Department. UHC uses eligibility dates received from State. If no PA was provided, would need to be re-requested.

**Claims Processing:**
1. When will claims processing information be available? (i.e. Payer ID for Electronic Claims)
   
   Starting day 1. Payer ID 87226, see Chapter 11 for more info.

2. How are local code items going to be handled by each Health Plan? Example, Any item on the Medicaid fee schedule with a “W” or “T” code. Are we to bill the local code, or the crosswalked HCPCS code? Please bill the HIPAA compliant HCPC code/ as well as the “W” code. We will operate off a crosswalk and work with DHHS to discuss the concerns around using non-HIPAA compliant codes.

3. Is there an expectation that Health Plans will accept claims in the same format as described in the attached document from the Medicaid manual 5A-2, specifically regarding rentals and enteral supply kits? (Snip Below). For the DME Rent to Purchase editing in place today we edit on calendar month.

Looking at the “Rental Equipment” section, you can see the billing rules for rentals are somewhat unique to NC Medicaid. A CPAP rental, for instance, would look something like: Date delivered 3/19/20, date picked up 10/20/20.

1. 3/19/20-3/31/20
2. 4/1/20-4/30/20
3. 5/1/20-5/31/20
4. 6/1/20-6/30/20
5. 7/1/20-7/31/20
6. 8/1/20-8/31/20
7. 9/1/20-9/30/20
8. 10/1/20-10/20/20

If we were following Medicare billing rules, the rental would look more like

1. 3/19/20-4/18/20
2. 4/19/20-5/18/20
3. 5/19/20-6/18/20
4. 6/19/20-7/18/20
5. 7/19/20-8/18/20
6. 8/19/20-9/18/20
### Contracted Provider:

1. The provider manual has limited billing information when it comes to DME-specific billing. The Medicaid Manuals 5A-1, 5A-2, 5A-3 and 5B are extremely detailed and important for billing staff to prepare billing systems for submitting claims. Are there any expectations for billing manuals to be released from the Health Plans? The UnitedHealthcare Administrative Guide is available on our website https://www.uhcprovider.com/content/dam/provider/docs/public/admin-guides/comm-plan/NC-UHCCP-Care-Provider-Manual.pdf

### Other Questions:

- Will portal have DME information or will we go to NCTracks. UHC follows CMS Guidelines/Above policies. Clinical (DME) (coverage and reimbursement) Policies are on portals (provided by State of NC). Links:
• Codes not listed on fee schedule (eg hospital bed)? UHC coverage for different HCPC code? Likely a SCA based on medical necessity and discussion whether there is an alternative that can be leveraged prior to benefit accommodation. May establish Gap/Fill if/as needed.

• Submit PA with DOS that fall into effective date of transition?: Not recommended (unless new). Member data will not be synced until after transition

• Existing PA, FFS that needs renewal in 90 day– what is expected TAT on these? Currently assessing work-load based on forecasts.