

WELLCARE – June 3, 2021

(organized by Eugenie Komives, Lisa Gibson, Talena Jones, Matt Oettinger, Trae Jackson, Thomas D'Andrea, Sheri Spainhour)

Questions for MCOs – NC Medicaid:

- 1. How do we handle recurring rentals when a beneficiary changes plans in mid-stream? Will the first authorization carry forward to the new payer? How will we even know when a patient changes plans?**

A – Sending auths to new PHP & they will have in hand during period of time. Then DME will need to obtain from PHP. NC Tracks have current health plans and Wellcare has a portal (each MCO does) to verify plans. Laura asked about batches – Lisa said yes. Kim asked about lifetime auth – like O2 patient. Recert needed after a year and retest not needed and wont be more stringent than the state. Kelsey ask about auths during first 90 days approval – auths will crossover in transition of care and ongoing.

- 2. Will any documentation requirements change from payer to payer?**

A – plans have states clinical coverage policy. State policy is the floor for coverage and plans can't be any more restrictive than the state. Doc requirements may vary from plan to plan. Example was given for oxygen lifetime authorization cycle, where after 36 months the patient can be approved for lifetime authorizations. This will not be the case for Wellcare.- EK said we should discuss this with the state & Laura agreed.

- 3. Can we be sent an email when a patient of ours changes plans?**

A – No.

- 4. Will the coverage criteria be the same from plan to plan?**

A – addressed above

- 5. Will the new MCOs follow current Medicaid policy regarding coverage criteria?**

A – adopted state's policy

- 6. What are the claims processing metrics that the MCO plans must meet and report to the state?**

A – Talena: 30 days for payment of a clean claim. Plans must send notice of claims receipt 18 days. If not processed timely, Interest 18% interest is applied plus 1% penalty per day. Must pay 99% of claims in 30 days. Average turnaround is 10-12 days. July 6 first check run. No runs on Sunday or Holidays or last day of the month.

Electronic Payer id is active with the clearinghouses, and providers can also submit claims on the portal, or send claims in the mail.

- 7. How will claims be submitted to each participating insurance contracted for managed care?**

- 8. Will NC Tracks be available for prior approval or will I go through each contracted insurance?**

A - Talena : receive paper and EDI. Paper claims have their own address. Lisa: Quick reference guide on how to etc. and can submit through portal. Must enroll through portal – it's active already. Lisa can help get set up or train "ncproviderrelations@wellcare.com". **Lisa will set up training for ACMESA.** Talena sending info.

9. Will NC Tracks be used for any beneficiary information or for submitting any claims?

A – No. each plan has own portal.

10. Will each individual insurance have it's own time limit for submitting claims or will they abide by Medicaid time limits?

A – State will not transfer claims. 180 day claim submission timely filing. Appeals timeframe is 60 days by contract. Routine PA they have 14 days (usual turnaround 5-7 days) – but one time extension of 14 days is allowed and member will be notified. Urgent PAs have a 72 hour turnaround time and provider can ask for expedited. Intent to deny may be sent and then peer to peer can be requested. If denied, then 60 days to appeal.

Prior approval really means prior approval. Auths must be obtained prior to delivery. This is different than the state.

This is very different than FFS – Providers be prepared – needed prior to provision!

EG: case by case basis will be considered in month retroactive eligibility and authorizations. If auth obtained in FFS then they will crossover.

11. My number 1 concern is coordination of current authorizations or lifetime Oxygen authorizations.

A – answered above

12. Authorizations – we need more information on process for each transitioning current NC Tracks authorizations to the new MCO.

a. **Some items like Oxygen have lifetime Authorizations.** A – yes will transition, but ongoing authorizations will be needed for ongoing rental.

b. **Will we need new forms and physician signatures or will they accept CMNPA DMA372-131** (A – will accept CMNPA but will ask for clinical records – attestation ok and often the prescription doesn't have all info.) Audit will not penalize if form not there. **Kelsey asked – can providers request auth before July 1 and known transition of care?** A – submit to FFS prior to July 1 at midnight. Plans will kick in July 1 and the plan will honor it. Wellcare staff is ready!

13. NC Medicaid requires rentals month to month (meaning you can't span 30 days into another month). Will MCO pays by day with same month 031521-033121 or months can spanned 30 days into next month for example: 031521-041421?

A – Example at the end of this doc. Medicaid manual wants calendar month and Medicare wants 30 days. Talena said it doesn't matter – Wellcare can process either way. 31 day month could deny one day but if Auth covers the date span, then it will be paid. **Kelsey about the 12 month???**

Followup question: Can Wellcare explain in more detail how the claims processing will work for rentals? We understand the claims system can handle the rentals either way, but what is the preferred method? Is there any audit risk if a provider chooses to bill on the calendar month?

14. How soon will we be notified of which plan the recipient will have?

A – Check NC Tracks a week or two in advance. Some plans are showing **now. 1.4M members to show – if auto enrolled will show next week.**

15. For incontinence supplies will it only be a physician order and notes showing need for the supplies or will there be an additional form to be completed like it is now (CMN/PA form for Medicaid)?

A – Don't need state CMN, just clinical. State doesn't require auto for INCO. Look at Wellcare website and chose NC and then Authorization look up – GREAT TOOL. **Trae/Talena to confirm and look at the oxygen rule - rental. Matt read the rule...** All DME rentals require authorization. DME purchases reimbursed at OR below \$500 per line item do NOT require authorization.

16. When will the MCO's start accepting information from DME providers to continue service for equipment and supplies already authorized?

A – Auths crossover July 1. State wanted all auth requests through NC Tracks until 7/1/21, even if delivery will take place after the go-live. Auths will crossover.

17. How will the MCO's handle request for equipment and supplies classified as E1399 miscellaneous equipment and W4047 (Medicaid) miscellaneous supplies?

A – Talena: local W code submit 1:1 match and will process according to code. Guidance is on the website and will show claim loop and pricing. **Lisa will show in our training!**
<https://www.wellcare.com/North-Carolina/Providers/Medicaid/Claims>
Other resource guides—"PHP Billing Guidance for Local W Code"

18. Can we ask for joint calls to be hosted by NC Medicaid and MCO plans to discuss any system issues? Goal is to avoid the long drawn-out system edits issues and denials experienced with the VA CCC+ transition (DMAS calls started a little too late). The calls need to begin now to prevent cash impact which many providers experienced in VA.

A – EG: Sure!

19. Wound care coverage – as far as we understand, most wound codes are not covered as DME under NC fee for service. So is that changing under managed care? If so, what codes are covered and what's the basis for reimbursement? Supplies/dressings – covered under HH but not DMEPOS in FFS.

A – PENDING – Wellcare will follow up.

20. CGM coverage – would it be covered under Medical/DME or RX benefit or dual. The State has it under RX benefit only today.

A – Tom: Same for MCOs – under Pharmacy benefit. Wellcare has a pharmacy help line.

21. What algorithm or enrollment formula will the State use starting May 15, 2021 during the Auto Enrollment period for beneficiaries who have not selected a health plan?

A – looking for member's PCP. If not in 18-24 months they will assign based on geography and age.

22. Will the MCO plans have specific portals used for prior authorizations/eligibility? If so, how soon?

A – training coming

23. Will MCO plans REQUIRE the NC CMN?

A - NO

24. How will MCOs handle exceeding quantity limits or non-covered supplies:

- a. Do we need to be enrolled in any specific waiver programs? Not MCO eligible
- b. If so and we are, is there a specific system we need to utilize?
- c. If not, how do we enroll?

25. Will we be able to bill with the NC MCD ID# or will we need unique ID's?

A – Lisa: Can bill with Wellcare or Medicaid ID – should be good all the time.

26. In regards to Prior Authorizations, specifically for emergent DME items such as Oxygen, Hospital Beds, Wheelchairs, etc., will the MCO's approve requests retroactively or should DME providers withhold service until the Prior Authorization is signed by the doctor and then submitted to the MCO for approval.

A - Typically no. Hospital discharge will be handled in advance. Extenuating circumstances may be considered. CAP-C transition to MCO auths will be managed.

END OF CALL HERE – 9:38 am – ACMESA to highlight the remaining questions and send to Eugenia for answers then we can perhaps schedule another call.

27. Medicaid Prior Approvals can take several days to be received/approved. With most MCOs, items over \$500 will require PA which would include enteral pumps for tube fed patients. What is the turn around time for authorizations on these timely items needing to be dispensed? Answered in question 10. Routine PAs have a 14 day requirement for the Health Plans to respond. However they are turning over in 5-7 days. The Health Plan does have the option of an extension of 14 more days if the required documentation is not obtained. There is an Expedited Request option. Turnaround time for expedited request is 72 hours.

28. Will providers be able to submit prior authorization requests before 7/1/21 to help spread out the transition over the full 90 days? Will providers have enough time to submit and receive back all authorizations for existing rentals before the end of the transition period along with all their new authorization requests for new equipment? Answered in question 16. No. Auth requests cannot be requested by the Health Plans before 7/1/21. Any requests prior to 7/1/21 must be made through NC Tracks and will follow the patient through the 90 transition period.

29. How will MCO's handle timely filing for claims for DME items where delays in obtaining approval for Oxygen, Hospital Beds, Wheelchairs, etc. caused delays in billing.

30. Will Coverage guidelines and Medical policy remain unchanged under managed care?
Duplicate of question 4 and 5.
31. We spend an inordinate amount of time “on-hold” with insurance companies every day, which is frustrating. People get impatient on-hold after a few minutes (we have some insurers with 4+ hours hold times), but waiting a few hours for an e-mail response is acceptable to most people. Will the MCO’s have people that we can contact by e-mail for answers to questions that we have?

Continuity of Care Questions

- Once open enrollment begins and beneficiaries select their plans, when will providers be made aware of the patient’s choice of plan? We would like to have some preparation time to coordinate the billing on these patients to ensure a smooth transition. moot
- Similarly, on the auto-assignment of health plans, when will the information of the selected health plan be made available to providers? The date of auto assignment is May 15, 2021. May 22, 2021 is the date (approximate) that is mentioned that the information will be transmitted to the Health Plan for the beneficiaries assigned to each one. Will providers know very shortly after May 22? moot
- 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.
- According to the Provider Playbook, Mandatory beneficiaries can change their Health Plan assignment in the first 90 days. Then if they want to change again, they have to have cause, how long is the expectation of the turn-around time for those “Cause” forms to be reviewed and the beneficiary to choose another plan? Will providers be made aware of the submission of the request to change plans? Again, specifically concerning to the DME industry because of rentals and other care that is continual.
- How are the Health Plans handling retroactive eligibility? Will providers be allowed to request authorizations retroactively in those cases?
- For dual eligible plans, has there been any discussion of how the process will work? Does the primary autocross over to the secondary without the provider having to send the claim? Will the primary dual eligible policy payment be considered payment in full? What about non-covered services for Medicare and Medicare MCOs, will those need to be billed to the “secondary” in those cases? Example, shower chairs, or incontinence supplies (diapers and underpads).
- 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 cross-walked HCPCs code?
- How will EPSDT situations be handled? Here are some scenarios where EPSDT is used.
 - If an item has an existing HCPCs code, but the patient requires a custom product that exceeds the fee schedule allowable.
 - Quantity overrides- if a doctor prescribes a monthly quantity greater than the max quantity in the policy.

- Codes not on the fee schedule-EPSDT is available for items that are not on the fee schedule for individual consideration.
- If a beneficiary is over 21, and not eligible for EPSDT, how would custom items, items not on the fee schedule, or miscellaneous items be handled?
- 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?
- 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)
 - 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
7. 9/19/20-10/18/20
8. 10/19/20-10/20/20

• Block #/Description	• Instruction
<ul style="list-style-type: none"> 24a. Date(s) of Service, From/To 	<ul style="list-style-type: none"> Your entry depends upon the services: <ul style="list-style-type: none"> Customized Equipment: You may enter either the date of the physician's prescription or the date of delivery to the beneficiary's home as the date of service. Place the date in the FROM block. Enter the same date in the TO block. Other Purchased Equipment - DME and EN: Enter the date the item is delivered to the beneficiary in the FROM block. Enter the same date in the TO block. Rental Equipment - DME and EN: For the month being billed, enter the first day in that month that the item is at the beneficiary's residence in the FROM block. Enter the last day in that month that the item is at the beneficiary's residence in the TO block. Do NOT span calendar months. <ul style="list-style-type: none"> <i>EXAMPLE: An enteral pump is provided from 3/25/02 through 5/15/02. Submit three claims. On March's claim, enter 032502 in the FROM block and 033102 in the TO block. On April's claim, enter 040102 in the FROM block and 043002 in the TO block. On May's claim, enter 050102 in the FROM block and 051502 in the TO block.</i> Service and Repairs: Enter the date that the item is serviced or repaired in the beneficiary's home as the date of service. If the item is removed from the beneficiary's home for service or repairs, enter the date that it is returned. Place the date in the FROM block. Enter the same date in the TO block. DME-Related Supplies: Enter the date that the item is delivered to the beneficiary's residence in the FROM block. Enter the same date in the TO block. EN Supply Kits: Enter the date in the month that the therapy begins in the FROM block. If the therapy is continued from the prior month, enter the first of the month in the FROM block. <ul style="list-style-type: none"> Enter the last day of therapy for the month in the TO block. If the therapy extends into the next month, enter the last day of the current month in the TO block. Do NOT span calendar months. See the <i>EXAMPLE</i> under Rental Equipment for guidance. EN Individual Supply Items: Enter the date that the item is delivered to the beneficiary in the FROM block. Enter the same date in the TO block. EN Formulae: Enter the service dates for the formula in the FROM and TO blocks.
<ul style="list-style-type: none"> 24b. Place of Service 	<ul style="list-style-type: none"> Enter 12 to show the items are provided at the beneficiary's residence.

Contracted provider questions

- What escalation process does a provider follow if there is an issue with a "Health Plan"? Can the provider submit complaints to the department at DHHS? Is there an Ombudsman that handles complaints?
- In other states, there are situations where Health Plans had contracted with providers, then after a year or so, restricted the network. Now providers are getting notices they are no longer in network after a certain date. Is this also an option in North Carolina to the health plans? If so, what kind of appeal process does a provider have? Do the Health Plans have to report on their 'provider network capacity'? What will reimbursement look like for an out of network provider if a rental will continue past the date of contract termination?
- If a provider changes their address, they need to make the necessary address change in NC Tracks, but will the provider also be required to inform the contracted Health plans with a W-9 or some other form? Additionally, will the health plans allow all claims submitted after the address change to have the current address? Or will it be date of service driven like NC Tracks?
- Will there still be a same/similar electronic check to determine months on rent or requests for duplicate equipment already purchased or on rent with another provider?