DURABLE MEDICAL EQUIPMENT (DME) PRIOR AUTHORIZATION (PA) PROCESS
FREQUENTLY ASKED QUESTIONS
WWW.DME.IDAHO.GOV

Question	Answer
1. When do I need to request a prior authorization (PA)?	A. To learn if a PA is required, check the current Medicaid Fee Schedule (www.dme.idaho.gov). Many HCPCS codes do not require a PA. In the search engine of the fee schedule excel sheet, enter the HCPCS code. If there is a "Y" In the PA indicator column, then a PA is required. B. Review eligibility at www.Idmedicaid.com to see if there is a limitation for the item. If so, a PA may be required if benefits have been exhausted.
2. What are the steps taken to obtain DME?	All requests require a prescription signed by a physician, nurse practitioner, or physician assistant. The prescription and documentation of medical necessity are given to a DME vendor enrolled with Idaho Medicaid. The vendor will evaluate the requested equipment to determine if the DME can be dispensed or if it requires a prior authorization.
3. How do I request a DME prior authorization?	To request a PA from the Medicaid Medical Care Unit, **fax** your request to (877) 314-8782. The Medical Care Unit **does not** accept phone, on-line, or emailed requests. A DME Prior Authorization Request Forms is required for your request. Fill in all the required information including the proposed date of service. Fax any pertinent supporting documentation which addresses the medical necessity of the proposed DME item along with your request form. The required Forms can be accessed at www.dme.idaho.gov

Question	Answer
	The nurse reviewer may request additional documentation to establish medical necessity for the item. The requested documentation must be received by the Medical Care Unit within two working days or the request may be denied. Authorizations are usually made within two working days, but complex requests may require additional time.
4. What is the process for requesting DME items not currently covered by Idaho Medicaid?	The first step is to visit your physician. If your physician agrees that you have a medical need for the item, he or she will write a doctor's order and a Letter of Medical Necessity. Then you will choose a supplier for that item, and the supplier will send the documents to Idaho Medicaid. Medicaid is continually adding new DME items that have not previously been authorized; however, if you receive a Notice of Decision informing you that the item you have requested has been denied, please contact your supplier with a letter from your physician addressed to the Idaho Medicaid Medical Director requesting a medical review.
5. What if the participant has Medicare Part B coverage plus traditional Medicaid?	For participants with active Medicare A&B, it is not necessary to submit a PA. Providers are to follow the Medicare requirements and submit claims to Medicare first. Medicaid is considered the payer of last resort. Providers are to enroll with the Idaho Medicaid Program separately from Medicare. If the participant is dually eligible for Medicare and Medicaid, Medicare must be billed first. The claims submitted electronically to Medicare through the DME MACs system are crossed over to Medicaid. Consult the General Billing Instructions for more information.
6. What if the participant has Medicare-Medicaid Coordinated Plan (MMCP) coverage?	For participants with active MMCP coverage, it is not necessary to submit a PA. Providers are to follow the Medicare requirements and submit claims to MMCP first which is a Medicare Advantage Plan. MMCP does not require any cost sharing for DME.

Question	Answer
7. How do I check the status of my Medicaid Medical Care Unit PA?	A Notice of Decision (NOD) for an approval or a denial will be mailed to the participant and/or to the provider by Medicaid. You may also go to your Trading Partner Account and check the form entry/authorization status link or call Molina Medicaid Solutions at 1 (866) 686-4272, option 3.
8. How do I appeal a decision made by the Medicaid's Medical Care Unit?	Appeal instructions are provided on the Notice of Decision letter that is mailed to the participant and/or provider. If the provider has additional information to support medical necessity, the provider may submit this information for further consideration and review to the Medical Care Unit. Fax this additional documentation with a PA request sheet to the DME fax at 1-877-314-8782.
9. Who do I contact if I have claim questions?	You can contact Molina Solutions at 1 (866) 686-4272. Claim payment questions can be answered by a Molina representative.
10. What is an "Urgent Request"?	An urgent request constitutes equipment the participant needs prior to discharge from a facility – for example, hospital, skilled nursing facility or rehabilitation facility. If you indicate on the PA request form that this is an "urgent" request and the date of discharge if known this will expedite the request.
11. Is an item covered by Medicaid?	Idaho Medicaid follows Medicare criteria. The criterion is available in the DMAC manual or is part of a local or national coverage determination (LCD or NCD). Medicare coverage criteria can be found at https://www.noridianmedicare.com/dme/coverage/lcd.html%3f. When no Medicare criteria available, the Department may establish criteria. See the DME supplier manual and/or the current Administrative Rules.

Question	Answer
	Many items are covered only when prior authorized. Providers should verify the actual procedure code that is listed in the fee schedule on the Department's website (www.dme.idaho.gov) to review if a PA is required. All DME items covered by Medicaid are listed in the fee schedule and are covered when medically necessary and the least costly means of meeting the participant's medical need. Medical equipment for purchase must be new when dispensed unless authorized by DHW as used. This includes equipment that is issued as "rent-to-purchase." It does not apply to short-term rental equipment. **Note:** Lift devices provided under the waiver program require PA.
12. How do I obtain DME if the participant resides in Skilled Nursing Facility (SNF)?	DME is the responsibility of the facility and is considered within the content of care. DME providers may not bill for DME or DMS for participants who are residing in a hospital, long-term care, or a skilled nursing facility. Please contact Bureau of Long Term Care. (208) 364-1891
13. How do I Modify an existing PA?	Fax the cover sheet with an explanation why a modification is needed and include any additional documentation if necessary.
14. What do I do when I see a $0.00 reimbursement amount on the fee schedule?	This is called a Manually priced item. For codes that are manually priced, including miscellaneous codes, a copy of an invoice or the manufacturer's suggested retail pricing (MSRP) or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping (if that documentation is provided).

Question	Answer
15. How would I obtain an adaptation of my home?	Environmental/home modifications are interior or exterior physical adaptations to the home. The participant must be on the Aged & Disabled waiver or the DD waiver. *For the A & D waiver please contact the regional bureau of long term care staff for further assistance. *For the DD waiver- Make a request for adaptations to the home through a request for Environmental Accessibility Adaptations as part of the Individual Service Plan (ISP) or through an Addendum.