Subject: Vendor Oversight for DME and Supplies	**Original Effective Date: 10/01/2020**
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HCS Approval Date:	

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Molina) for a particular member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements from the State of Illinois, Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this Molina Clinical Policy (MCP) document and provide the directive for all Medicare members.

POLICY

Compliance with Illinois HFS M-205 requires Molina Healthcare, Illinois (MHIL) DME and supply vendors meet HFS requirements and MHIL providing oversight of the vendors' procedures.

DESCRIPTION OF PROCEDURE – UTILIZATION MANAGEMENT

Approval for medical equipment and supplies follows standard UM processes. All approvals require the following:

- Requests from DME or supply companies for new items will not be accepted without the member's physician or provider supplying the clinical information documenting medical necessity.
- Requests must include the current provider's order, the member recipient's name and identifying information (either Molina ID, Date of Birth or other identifying information).
- The provider must document why the equipment or supplies are medically necessary.
- Past authorizations must be reviewed for each new request, to determine if excess DME or supplies have been requested.
- The standard UM review process is followed, with review of the Prior Authorization Guide, HFS Fee Schedule and clinical policies and guidelines, per the Molina UM Hierarchy for Determinations.
- All requests not meeting medical necessity or not including needed information will be sent to medical directors for review.

- All high dollar requests (over $3,000) are sent to medical directors for review.
- Quarterly review of PA DME and supply requests and approvals will be completed by the analytics team with UM leadership to identify outliers or areas requiring additional focus.
- Vendors appearing to be outliers, based on quarterly review (or for any other reason) are to be submitted to the Fraud, Waste and Abuse team for further investigation.

DESCRIPTION OF PROCEDURE – NETWORK OPERATIONS MANAGEMENT

With each new contracted vendor and at least on an annual basis, MHIL Network Operations will review expectations that all vendors meet the HFS requirements for DME and supplies to MHIL membership. These include, but are not limited to:

- Confirmation that all orders meet what was authorized by MHIL.
- Confirmation should include number and type of items needed.
- Vendors must speak to the member, a designated family member or caregiver to make sure the type and quantity of DME or supplies are consistent with what was authorized.
- Confirmation calls to the member, family member or caregiver should be made no more than 14 calendar days prior to the scheduled shipment day.
- Auto-confirmation calls by interactive voice response or robo-calls are not acceptable.
- Documentation of who confirmed the order must be in the vendor's file.
- Orders not confirmed are not to be dispensed.
- If the vendor cannot reach the member, family member or caregiver, the vendor should contact MHIL to review contact phone numbers.
- Vendors must retain proof of delivery in the MHIL member's file.

All vendors are subject to spot audits by the MHIL Network Operations team at any time. Failing required procedures may result in required corrective action plans up to termination of vendor contract.

DEFINITIONS

CMS: Centers for Medicare & Medicaid Services
DME: durable medical equipment
Hierarchy for Determinations: guidelines used for medical necessity determinations.

1. Applicable Federal mandates and CMS Guidelines: National Coverage Determinations (NCD), Local Coverage Determinations (LCD)
2. Illinois State Regulations and State Specific Criteria Guideline Sets
3. Delegated 3rd party clinical criteria guidelines approved for UM use in compliance with Molina policies (eviCore
4. Corporate guidance documents and policies, including Molina Clinical Policy (MCP), Molina Clinical Review (MCR).
5. Licensed external decision making criteria: InterQual® Criteria, MCG, American College of Radiology (ACR)
6. National Comprehensive Cancer Network (NCCN)

7. Hayes Technology Assessment, UpToDate, other technology assessments established by nationally accepted government agencies, physician specialty societies, associations or academies and published in peer-revewed medical literature.
8. Well-controlled studies published and referenced in medical or scientific literature with relevant clinical evidence supporting the requested modality.
9. Specialty consultations by a third party reviewer or an Independent Revie Organization.

UM: utilization management

Vendor: provider supplying DME or clinical supplies

REFERENCES

Illinois HFS Record Requirements (Topic M-205 and M-203)

Revision/Review History: