

# DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS FOR PENNSYLVANIA PROVIDERS

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## DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS


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### Introduction and overview

Effective January 1, 2012, the PAP Quality Pay-for-Performance Program was introduced for positive airway pressure (PAP) devices, accessories, and supplies. This program was developed to positively impact four areas of patient care: quality, access, patient experience, and cost.

Highmark Blue Shield (“Highmark”) introduced this program to provide enhanced reimbursement opportunities for participating Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers who meet the program’s criteria and guidelines. All Highmark commercial network participating providers who provide members with PAP devices and/or accessories and supplies are eligible to participate in the program.

Participating providers are required to measure device usage compliance on a quarterly basis for Highmark Qualified Members to whom they supply continuous positive airway pressure (CPAP) devices, respiratory assist devices (RADs), and/or supplies and accessories for those devices (*see page 4*). For purposes of this program, the term “PAP device” will be used to reference all CPAPs and RADs.

Every year, each provider’s reimbursement level for the following calendar year will be based on the final compliance data that is submitted and the final Compliance Score that is automatically calculated on the Compliance Data Worksheet. 

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### IMPORTANT!

**Please note that, beginning in year 2014 and beyond, the Compliance Data Worksheet must be received by Highmark no later than **October 1** each year.**

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### Provider participation requirements

To participate in the PAP Quality Program, providers must:

- Sign a Durable Medical Equipment Quality Program Participation Agreement. By signing the agreement, the provider agrees to follow the program requirements outlined in this document for measuring and reporting member compliance for the use of PAP devices and supplies.
  - Maintain DMEPOS accreditation through at least one of the following Centers for Medicare & Medicaid Services (CMS) approved accrediting organizations:
    - Accreditation Commission for Health Care, Inc. (ACHC)
    - American Board for Certification in Orthotics & Prosthetics, Inc. (ABC)
    - Board of Certification/Accreditation International (BOC)
    - Commission on Accreditation of Rehabilitation Facilities (CARF)
    - Community Health Accreditation Program (CHAP)
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# DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

**Provider participation requirements**  
(continued)

- HealthCare Quality Association on Accreditation (HQAA)
- National Association of Boards of Pharmacy (NABP)
- The Compliance Team, Inc. (TCT)
- The Joint Commission

**IMPORTANT NOTE:**

**A separate agreement must be signed for each tax identification number under which the provider bills for PAP devices and accessories.**



**Reimbursement levels**

The PAP Program is based on a tiered reimbursement methodology. **The reimbursement cycle follows the calendar year: January 1 - December 31.** Participating providers are reimbursed according to the performance criteria detailed below.

The program’s Base Fee Schedule is consistent with current industry benchmarks. The program’s Enhanced Fee Schedule provides additional reimbursement opportunities for providers based on their final Compliance Scores.

Effective January 1, 2013, the tiered reimbursement for PAP devices and accessories was implemented as follows:

**1. Base Program Fee Schedule:**

Base Rate = 65% of CMS DMEPOS Fee Schedule  
(Medicare Advantage - 85% of CMS DMEPOS Fee Schedule)

**2. Enhanced Program Fee Schedule: \***

Rate based on Provider’s Compliance Score as described in the table below.  
(Medicare Advantage - 85% of CMS DMEPOS Fee Schedule)

COMPLIANCE SCORE	ENHANCED PROGRAM FEE SCHEDULE
60% – 80%	75% of CMS DMEPOS Fee Schedule
> 80%	85% of CMS DMEPOS Fee Schedule

**\*The Enhanced Fee Schedule for Select DME Network providers is 75 percent (75%) of the CMS DMEPOS Fee Schedule as of January 1, 2017. This is the only reimbursement level for participating PAP Quality Program providers in the Select DME Network. Please refer to your Highmark Ancillary Agreement to verify your contracting status.**

**IMPORTANT NOTE:**

**If a participating provider’s Compliance Score is less than sixty (60) percent, the provider’s reimbursement will be paid at the program’s Base Fee Schedule level.**



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# DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

**IMPORTANT FOR NEW PROVIDERS: Eligibility guidelines for enhanced reimbursement**

New providers will be eligible to receive enhanced reimbursement once the provider has:

1. Executed the Participation Agreement;
2. Completed a full 12-month measurement cycle (July 1 – June 30); and
3. Met the appropriate program requirements.

Participating providers will receive reimbursement according to the program’s Base Fee Schedule level until requirements for the enhanced reimbursement are met for the applicable measurement period.

**IMPORTANT NOTE: Eligibility guidelines for enhanced reimbursement do not apply to Select DME Network providers. Please refer to Page 3 for Select DME Network reimbursement details.**



**Applicable procedure codes**

The PAP devices included in this program are identified as follows:

- E0601: single-level continuous positive airway pressure (CPAP) device
- E0470: bi-level pressure respiratory assist device without backup rate feature
- E0471: bi-level pressure respiratory assist device with back-up rate feature

The applicable accessories for use with PAP devices are those identified by the following procedure codes:

A4604	A7031	A7036	A7045
A7027	A7032	A7037	A7046
A7028	A7033	A7038	E0561
A7029	A7034	A7039	E0562
A7030	A7035	A7044	

**Medical Policy and authorization requirements**

Coverage for PAP devices and accessories is based on medical necessity and the member’s benefit plan. For medical necessity coverage guidelines, please refer to Highmark commercial and Medicare Advantage Medical Policies E-20, E-50, and E-34.

**Note:** The Federal Employee Program (FEP) does not follow Highmark Medical Policy guidelines. FEP’s medical necessity and appropriateness guidelines, including medical policies related to PAP devices, apply to services provided to FEP members.



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## DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

**Medical Policy and authorization requirements** (continued)

In addition, authorization requirements apply for those members with benefit plans requiring authorization for PAP devices. For more information on procedures requiring authorization, go to the Provider Resource Center and select *Administrative Reference Materials* from the main menu.



**Measurement year for compliance**

**The measurement year for PAP Program compliance runs from July 1 through June 30.** The measurement year is divided into quarterly measurement periods as indicated in the table below.

**Providers may submit final compliance data for the four quarterly measurement periods, which also include the two-quarter look-back periods for each quarter, beginning July 1.**

**ALL FINAL COMPLIANCE DATA MUST BE RECEIVED BY HIGHMARK NO LATER THAN THE OCTOBER 1 DEADLINE.**

MEASUREMENT YEAR	QUARTERLY MEASUREMENT PERIODS		DATA SUBMISSION DEADLINE	REIMBURSEMENT RATE EFFECTIVE DATE
July 1 – June 30	Qtr 1	July – September Plus: 2-quarter look-back period (January – June)	<b>October 1</b>	January 1 of the next calendar year
	Qtr 2	October – December Plus: 2-quarter look-back period (April – September)		
	Qtr 3	January – March Plus: 2-quarter look-back period (July – December)		
	Qtr 4	April – June Plus: 2-quarter look-back period (October – March)		

**IMPORTANT!**

**Highmark Qualified Members include those members who have had Highmark claims processed for any applicable HCPCS codes during the 9-month Qualified Member Identification Period.** (Please refer to the example on page 7.)



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## DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

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### How to identify Highmark Qualified Members

#### **IMPORTANT:**

To accurately count Highmark Qualified Members, please include ALL of the following:

**All patients who have Highmark primary/secondary insurance and for whom a claim was processed through Highmark, and:**

- Received a PAP device and it has been determined that the continued use of the PAP device is medically necessary according to Highmark Medical Policy or FEP medical policies/guidelines.
- Highmark retiree health plans.
- Federal Employee Program (FEP) members.
- All “active members” who have received a PAP device and/or supplies within the measurement quarter PLUS the two-quarter look-back period (total of nine (9) months).
- Include “new members” in the measurement quarter where they have completed the 90-day initial device usage based on Highmark Medical Policies E-20, E-34, and E-50.
- Blue Plan members hosted in Highmark service regions.

**PLEASE NOTE:** When Medicare is primary, BlueCard® rules do not apply.



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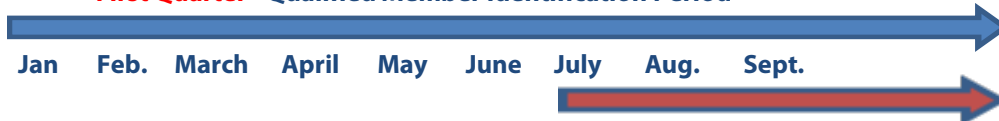
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# DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

## EXAMPLE: How to Accurately Count Highmark Qualified Members

The following example illustrates, on a quarterly basis, the Qualified Member Identification Period, each Compliance Measurement Quarter, and the time frames when compliance data should be collected from Qualified Members.

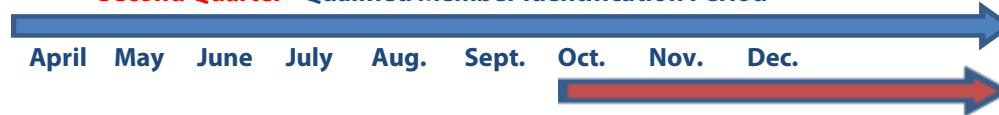
### First Quarter - Qualified Member Identification Period



### First Quarter - Compliance Measurement Period

- **Qualified Member Identification Period:** Jan. 1 – Sept. 30 (includes 2-quarter look back)
- **Compliance Measurement Quarter:** July 1 – Sept. 30 (provider contacts members)
- **Compliance Data Collected From Qualified Members:** Between July 1 and Sept. 30

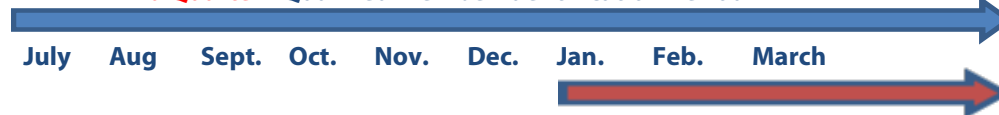
### Second Quarter - Qualified Member Identification Period



### Second Quarter - Compliance Measurement Period

- **Qualified Member Identification Period:** April 1 – Dec. 31 (includes 2-quarter look back)
- **Compliance Measurement Quarter:** Oct. 1 – Dec. 31 (provider contacts members)
- **Compliance Data Collected From Qualified Members:** Between Oct. 1 and Dec. 31

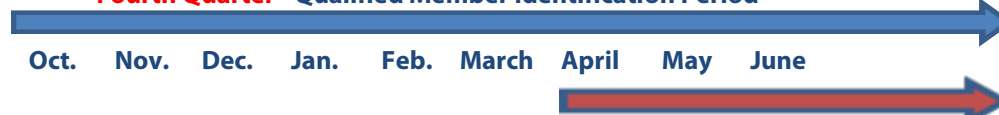
### Third Quarter - Qualified Member Identification Period



### Third Quarter - Compliance Measurement Period

- **Qualified Member Identification Period:** July 1 – March 31 (includes 2-quarter look back)
- **Compliance Measurement Quarter:** Jan. 1 – March 31 (provider contacts members)
- **Compliance Data Collected From Qualified Members:** Between Jan. 1 and March 31

### Fourth Quarter - Qualified Member Identification Period



### Fourth Quarter - Compliance Measurement Period

- **Qualified Member Identification Period:** Oct. 1 – June 30 (includes 2-quarter look back)
- **Compliance Measurement Quarter:** April 1 – June 30 (provider contacts members)
- **Compliance Data Collected From Qualified Members:** Between April 1 and June 30



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## DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

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### EXAMPLES HOW TO ACCURATELY COUNT HIGHMARK QUALIFIED MEMBERS: Scenario Examples

**EXAMPLE A: Counting Highmark Qualified Members using the two-quarter look-back period.** Highmark member John Smith received a new CPAP device on January 15 and the initial 90-day usage period ended on April 15. Since the member received the device during the two-quarter look-back period, and the initial 90-day usage period ended during the two-quarter look back period, the member would be counted in the first quarter (July - September) which also includes the two-quarter look-back period (January - June).

Therefore, the Total Qualified Highmark Member identification period in this example would be January – September (measurement period PLUS the two-quarter look-back period). **IMPORTANT REMINDER:** Begin to count new Highmark Qualified Members after they have completed the 90-day initial device usage period.

**EXAMPLE B: Counting Highmark Qualified Members when Highmark is the Secondary Payer.** Catherine Jones has Medicare coverage and a supplemental Medigap policy through Highmark. She received supplies on November 1. The claim then crossed over to Highmark after the Medicare payment; however, no payment was made because Highmark's allowance was the same as the Medicare allowance. Only a small copayment was due and paid by Catherine.

In this example, the member would be counted in the second quarter (October - December). The Total Highmark Qualified Member Identification Period in this example would be April – December (measurement period PLUS the two-quarter look-back period).

**EXAMPLE C: Counting Highmark Qualified Members with coverage through another Blue Plan (BlueCard®).** Jim Jenkins is employed by a company that is based in Alabama but he works and resides in Pittsburgh. His company provides BlueCard PPO coverage through Blue Cross and Blue Shield of Alabama. Jim received a CPAP device on January 3 from a Highmark PPO participating provider in Pittsburgh. The provider submitted the claim to Highmark, their local plan, and then Highmark forwarded the claim internally via BlueCard to the Alabama Blue Plan. Blue Cross and Blue Shield of Alabama adjudicated the claim and sent the information back to Highmark. The provider received the payment for the BlueCard claim from Highmark, their local plan, on January 17.

In this example, the member with BlueCard PPO coverage through Blue Cross and Blue Shield of Alabama would be counted in the third measurement quarter (January – March). The Total Qualified Member Identification Period for this example would be July – March (measurement quarter PLUS the two-quarter look-back period). ↑

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## DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

### Defining and measuring member compliance

Providers must use the following criteria to determine if a Qualified Member is compliant on a quarterly basis:

**“Member uses the PAP device a minimum of four (4) hours per night, seventy (70) percent of the nights during each quarterly measurement period.”**

Compliance data can be obtained by any of the following methods:

- Patient self-reporting
- Electronic compliance measurement devices
- Modems
- Automated or live telephonic validation provided by a third-party vendor



### IMPORTANT!

**Compliance data must be collected for a Highmark Qualified Member every quarter for as long as the member continues to be a patient of the provider and claims for the member are being processed by Highmark. This applies to rented or purchased devices and all purchased supplies.**

### Annual Compliance Data Worksheet submission to Highmark

**Participating providers should enter compliance data into the online Compliance Data Worksheet on a quarterly basis.** The Compliance Data Worksheet will automatically calculate the provider’s Compliance Score for the measurement year based on the data entered by the provider for the four quarterly measurement periods.

The calculation is based on quarterly compliance data entered by the provider for Highmark Qualified Members from all provider locations represented under the provider’s tax identification number(s). *(See page 10.)*

Final annual compliance data can be submitted to Highmark beginning July 1 and by no later than the **October 1** deadline.

**Participating providers are required to document the following data for each quarterly measurement period:**

- **Total number of Highmark Qualified Members** *(refer to page 10)*
- **Number of Highmark Qualified Members who were contacted and for whom compliance data was obtained**
- **Number of Highmark Qualified Members for whom compliance data was obtained and WHO MET compliance criteria**



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## DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

### IMPORTANT! Qualifying members reporting requirement

Each provider must obtain and include compliance data for a **minimum of seventy (70) percent** of the qualifying member population. If less than seventy (70) percent is reported, the provider will be reimbursed at the program's Base Level.

**Note:** The seventy (70) percent minimum applies beginning with the 12-month measurement period July 1, 2016 through June 30, 2017 for reimbursement for calendar year 2018. (This is a change from sixty (60) percent for prior measurement periods.)



### Compliance Score calculation

Final Compliance Scores are automatically calculated on the Compliance Data Worksheets based on the data that is entered by the provider. The following is an explanation of how the scores are calculated:

1. Calculate the percentage of Highmark Qualified Members included in the compliance measurement - **providers must meet a minimum of 70% of Highmark Qualified Members as an Annual Average to be eligible for the program:**

**Number of Highmark Qualified Members measured (each quarter totaled) divided by Total Number of Highmark Qualified Members (each quarter totaled) = Annual Average**

**Example:  $(69 + 70 + 90 + 73) / (103 + 103 + 106 + 107) = 72\%$**   
(Eligible for the program)

2. Calculate the provider's annual Compliance Score as follows:

**Number of Highmark Qualified Members measured who meet compliance criteria (each quarter totaled) divided by Number of Highmark Qualified Members measured (each quarter totaled) = Annual Compliance Score**

**Example:  $(60 + 45 + 80 + 69) / (69 + 70 + 90 + 73) = 84\%$**   
(Eligible for enhanced reimbursement)



### IMPORTANT!

Please keep in mind that Highmark Qualified Members include those members for whom claims have been processed by Highmark for any of the program's applicable HCPCS codes during the 9-month Qualified Member Identification Period. Please refer to the Example on page 7 that illustrates the 9-month Qualified Member Identification Period for each quarter.

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## DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

**EXAMPLE:  
Compliance  
data reporting  
and scoring**

The illustration below provides an example of the data reporting and calculation of the provider’s Compliance Score.

The compliance measurement must include at least seventy (70) percent of the Highmark Qualified Member population. In this example, the provider included seventy-two (72) percent of the Highmark Qualified Member population in its compliance scoring.

The provider’s Compliance Score for the measurement year is eighty-four (84) percent; therefore, the provider is eligible to receive the higher level of the program’s Enhanced Fee Schedule. The provider’s reimbursement for the next calendar year would be 85 percent of the CMS DMEPOS Fee Schedule (85 percent for Medicare Advantage).\*

**\*The Enhanced Fee Schedule for Select DME Network providers is 75 percent (75%) of the CMS DMEPOS Fee Schedule as of January 1, 2017. This is the only reimbursement level for participating PAP Quality Program providers in the Select DME Network. Please refer to your Highmark Ancillary Agreement to verify your contracting status.**

**PLEASE NOTE:**

Shaded fields below indicate data that must be entered on the electronic spreadsheet by participating providers for each quarter. All other fields are automatically calculated on the spreadsheet.



	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	AVERAGE
<b>Total Number of Highmark Qualified Members</b>	103	103	106	107	419	104.8
<b>Number of Highmark Qualified Members measured (members for whom compliance data was obtained)</b>	69	70	90	73	302	75.5
<b>Number of Highmark Qualified Members measured who meet compliance criteria</b>	60	45	80	69	254	63.5
<b>Percentage of Highmark Qualified Members included in the compliance measurement</b>	67.0%	67.9%	84.9%	68.2%		<b>72%</b>
<b>Compliance Score for the measurement period</b>	87.0%	64.0%	88.9%	94.5%		<b>84%</b>

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## DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

### Compliance Data Worksheet submission deadline and methods


**The completed Compliance Data Worksheet must be received by Highmark by the **October 1** deadline each year.** If the compliance data is not received by October 1, the provider's reimbursement for the following calendar year will be made at the program's Base Level.

The completed spreadsheet can be submitted to Highmark either electronically or by mail/hard copy as follows:

**Email to:** [HighmarkDQP@highmark.com](mailto:HighmarkDQP@highmark.com)


**Fax to:** 1-717-635-4221

**Mail to:** Ancillary Provider Strategy  
120 5<sup>th</sup> Avenue  
Suite 1451  
Pittsburgh, PA 15222  
- Personal and Confidential -

**Please Note:** When submitting compliance data via email, you will receive an automatic reply message that confirms receipt of your data. If you do not receive the confirmation, please follow up with Highmark to ensure your compliance data was successfully submitted. 

### IMPORTANT! Audit requirements and provider responsibilities

#### ANNUAL AND PERIODIC AUDITS:

- Pursuant to Section 4.1 of the DMEPOS Quality Program Agreement, all participating providers are required to comply with any and all audits that may be performed by Highmark to ensure compliance with the program's requirements.
- To ensure that you are prepared to respond to an audit request, please retain the following information:
  - Total number of Highmark Qualified Members for each quarterly measurement period AND the two-quarter look-back period (total of nine [9] months).
  - Total number of Highmark Qualified Members who were contacted and the dates they were contacted during each quarterly measurement period.
  - Total number of Highmark Qualified Members who were contacted **and who met the compliance criteria** during each quarterly measurement period.
  - Member names and unique Member IDs (UMIs).
- **Reimbursement will be based on the final audit results.** 

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# DMEPOS PAP QUALITY PROGRAM ADMINISTRATIVE REQUIREMENTS, Continued

**IMPORTANT!**  
Audit requirements and provider responsibilities (continued)

- **Failure to respond to an audit may result in a reimbursement level decrease to the Base Level.**
- **See *Best Practices* (located on the Provider Resource Center) for details regarding proper supporting documentation information.**

**TIME-SAVING SUGGESTION:**

A best practice and simple method of reporting the above information when requested is in an Excel spreadsheet.



**Quick Reference Table**

The table below summarizes the key requirements and deadlines for participating providers that will determine reimbursement levels for this year, next year, and beyond.

	2016	2017	And beyond
<b>Requirements</b>	12-month compliance measurement: July 1, 2014 – June 30, 2015	12-month compliance measurement: July 1, 2015 – June 30, 2016	12-month compliance measurement year: July 1 – June 30
<b>Deadlines</b>	Final Compliance Data Worksheet submission to Highmark <b>by Oct. 1, 2015</b>	Final Compliance Data Worksheet submission to Highmark <b>by Oct. 1, 2016</b>	Final Compliance Data Worksheet submission to Highmark <b>by Oct. 1 deadline</b>
<b>Reimbursement</b>	Jan. 1 – Dec. 31, 2016 Determined by Compliance Score*	Jan. 1 – Dec. 31, 2017 Determined by Compliance Score*	<ul style="list-style-type: none"> <li>▪ Effective Jan. 1 – Dec. 31 following the end of the applicable measurement year</li> <li>▪ Determined by Compliance Score*</li> </ul>

\* Please refer to page 3 for levels of reimbursement. Reimbursement levels are also dependent on the provider complying with the terms of the Durable Medical Equipment Quality Program Participation Agreement and satisfying all program requirements.

**PLEASE NOTE:**

- **Reimbursement for non-participating providers is made at the program’s Base Fee Schedule level.**
- **The Enhanced Fee Schedule for Select DME Network providers is 75 percent (75%) of the CMS DMEPOS Fee Schedule as of January 1, 2017. This is the only reimbursement level for participating PAP Quality Program providers in the Select DME Network. Please refer to your Highmark Ancillary Agreement to verify your contracting status.**

