

# DME Quarterly Update

January 8, 2020

# Agenda

1. DMEPOS Interim Fee Schedule, 1/1/2020
2. AU, AW, AV modifier additions
3. KU modifier addition
4. Capped Rental 13 month rental period
5. Unaltered Invoice, Shipping Receipt
6. Update to Pricing Research Request for B4088
7. Question & Answer

## Alaska Medical Assistance: State Fiscal Year 2020 Fee Schedule

### Durable Medical Equipment and Prosthetics & Orthotics Services

#### Interim Fee Schedule 2020Q1

Effective Dates of Service 1/1/2020 - 3/31/2020

1. Services or items that exceed the maximum allowed quantity in the specified timeframe require a service authorization prior to rendering/dispensing services or items. *7 AAC 120.210(b)(2)*
2. Time Frame Abbreviations

<i>M</i> - Per Month	<i>Y</i> - Per Year
<i>2M</i> - Per 2 Months	<i>2Y</i> - Per 2 Years
<i>3M</i> - Per 3 Months	<i>3Y</i> - Per 3 Years
<i>6M</i> - Per 6 Months	<i>5Y</i> - Per 5 Years
<i>DOS</i> - Per Date of Service	<i>7Y</i> - Per 7 Years
3. All services and maximum allowed quantities are subject to NCCI procedure-to-procedure or medically unlikely units editing even if prior authorized. Services that receive an NCCI exception may be submitted to first level appeals. Appeals for NCCI denials must be accompanied by original prescription orders and applicable medical records demonstrating medical necessity. Appeals will be reviewed on a case-by-case basis.
4. Claims for unpriced DME submitted without an unaltered final purchase invoice or with anything other than an unaltered final purchase invoice will be denied. Refer to the billing manual for more information.
  - [DME Unaltered Invoice](#)
  - [P&O Unaltered Invoice](#)
5. Additional References
  - [Medicare Fee Schedule](#)
  - [National Correct Coding Initiative \(NCCI\) Edits](#)
  - [DME Local Coverage Determinations - Jurisdiction D](#)
  - [DME National Coverage Determinations](#)

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Coverage and rates are subject to change.

# Interim Fee Schedule Layout Changes

Procedure Code	Procedure Code Description	DME	P&O	Service Auth Required	Claims Attach Required	NDC Required	Max Qty Allowed	Per Timeframe	Max Purchase Rate	Max Rental Rate	Capped Rental Month 1-3 (RR)	Capped Rental Month 4-13 (RR K.J)	Additional Billing Notes
A4360	DISPOSABLE EXT URETHRAL DEV	X	X				30	M	\$0.73	-	-	-	
A4361	OSTOMY FACE PLATE	X	X				1	2 M	\$31.09	-	-	-	May not be unbundled from A4375, A4376, A4379 A4380
A4362	SOLID SKIN BARRIER	X	X				20	M	\$4.01	-	-	-	
A4363	OSTOMY CLAMP, REPLACEMENT	X	X				2	M	\$2.32	-	-	-	May be billed for replacement only
A4364	ADHESIVE, LIQUID OR EQUAL	X	X				4	M	\$2.56	-	-	-	
A4366	OSTOMY VENT	X	X				2	M	\$1.50	-	-	-	May be billed for replacement only; may not be unbundled from A4416-4419, A4423-25, A4427
A4367	OSTOMY BELT	X	X				1	M	\$8.17	-	-	-	
A4368	OSTOMY FILTER	X					2	M	\$0.29	-	-	-	May be billed for replacement only
A4369	SKIN BARRIER LIQUID PER OZ	X	X				2	M	\$2.09	-	-	-	
A4371	SKIN BARRIER POWDER PER OZ	X	X				10	6 M	\$4.18	-	-	-	
A4372	SKIN BARRIER SOLID 4X4 EQUIV	X	X				30	M	\$4.90	-	-	-	
A4373	SKIN BARRIER WITH FLANGE	X	X				30	M	\$7.35	-	-	-	
A4375	DRAINABLE PLASTIC PCH W FCPL	X	X				5	M	\$20.12	-	-	-	
A4376	DRAINABLE RUBBER PCH W FCPLT	X	X				5	M	\$55.83	-	-	-	
A4377	DRAINABLE PLSTIC PCH W/O FP	X	X				10	M	\$5.03	-	-	-	May not be unbundled from A4375 if provided concurrently
A4378	DRAINABLE RUBBER PCH W/O FP	X	X				5	M	\$36.07	-	-	-	May not be unbundled from A4376 if provided concurrently
A4379	URINARY PLASTIC POUCH W FCPL	X	X				5	M	\$17.63	-	-	-	
A4380	URINARY RUBBER POUCH W FCPLT	X	X				3	M	\$43.78	-	-	-	

- Addition of Max Quantity information
- Addition of Capped Rental rate information
- Increased information in Additional Billing Requirements column
- Available in PDF and Excel versions

# AU, AV, AW Modifiers

## ▶ AU Modifier

- ▶ Item furnished in conjunction with a urological, ostomy, or tracheostomy supply

## ▶ AV Modifier

- ▶ Item furnished in conjunction with a prosthetic device, prosthetic or orthotic

## ▶ AW Modifier

- ▶ Item furnished in conjunction with a surgical dressing

- Codes A4450 and A4452 require AU, AV or AW modifier
- Code A5120 requires AU or AV modifier
- Codes A6531, A6532 and A6545 require AW modifier
- Claims for codes without appropriate modifier will be denied

# Complex Rehabilitative Wheelchair Options & Accessories

## KU Modifier

- ▶ Use of HCPC/KU modifier combinations are only valid:
    - ▶ When furnished in conjunction with a Group 3 complex rehabilitative power wheelchair
    - ▶ For replacement parts required for patient owned equipment where the appropriate wheelchair base is indicated in the beneficiary file and previously provided by Medicaid.
  - ▶ Service Authorization is required and must identify the KU Modifier, regardless if the HCPC code without the modifier requires a service authorization.
  - ▶ Group 3 complex rehabilitative power wheelchairs are described by codes K0848 thru K0864.
  - ▶ HCPC/KU modifier combinations are indicated on the DMEPOS Interim Fee Schedule for DOS on/after 1/1/2020.
- References (not limited to):
    - CMS Publication 100-04 Medicare Claims Processing, Transmittal 3535, dated June 7, 2016
    - CMS Medicare Learning Network, MLN MM9642
    - CMS Quarterly Fee Schedule publications

Procedure Code	Procedure Code Description	DME	P&O	Service Auth Required	Claims Attach Required	NDC Required	Max Qty Allowed	Per Timeframe	Max Purchase Rate	Max Rental Rate	Capped Rental Month 1-3 (RR)	Capped Rental Month 4-13 (RR KJ)	Additional Billing Notes
E0971 RR	WHEELCHAIR ANTI-TIPPING DEVI	X	X				2	M	-	\$4.14	-	-	
E0973	W/CH ACCESS DET ADJ ARMREST	X	X				2	Y	\$76.11	-	-	-	
E0973 KU	W/CH ACCESS DET ADJ ARMREST	X	X	X			2	Y	\$87.09	-	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0973 RR	W/CH ACCESS DET ADJ ARMREST	X	X				2	M	-	\$7.60	-	-	
E0973 RR KU	W/CH ACCESS DET ADJ ARMREST	X	X	X			2	M	-	\$8.69	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0974	W/CH ACCESS ANTI-ROLLBACK	X	X				2	Y	\$24.52	-	-	-	
E0974 RR	W/CH ACCESS ANTI-ROLLBACK	X	X				2	M	-	\$2.44	-	-	
E0978	W/C ACC,SAF BELT PELV STRAP	X	X				1	Y	\$35.59	-	-	-	
E0978 KU	W/C ACC,SAF BELT PELV STRAP	X	X	X			1	Y	\$45.07	-	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0978 RR	W/C ACC,SAF BELT PELV STRAP	X	X				1	M	-	\$3.56	-	-	
E0978 RR KU	W/C ACC,SAF BELT PELV STRAP	X	X	X			1	M	-	\$4.51	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0980	WHEELCHAIR SAFETY VEST	X	X				1	5 Y	\$32.55	-	-	-	
E0980 RR	WHEELCHAIR SAFETY VEST	X	X				1	M	-	\$3.24	-	-	
E0981	SEAT UPHOLSTERY, REPLACEMENT	X	X				1	5 Y	\$66.90	-	-	-	
E0981 KU	SEAT UPHOLSTERY, REPLACEMENT	X	X	X			1	5 Y	\$92.58	-	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0981 RR	SEAT UPHOLSTERY, REPLACEMENT	X	X				1	M	-	\$6.69	-	-	
E0981 RR KU	SEAT UPHOLSTERY, REPLACEMENT	X	X	X			1	M	-	\$9.26	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0982	BACK UPHOLSTERY, REPLACEMENT	X	X				1	5 Y	\$66.31	-	-	-	
E0982 KU	BACK UPHOLSTERY, REPLACEMENT	X	X	X			1	5 Y	\$86.98	-	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0982 RR	BACK UPHOLSTERY, REPLACEMENT	X	X				1	M	-	\$6.63	-	-	
E0982 RR KU	BACK UPHOLSTERY, REPLACEMENT	X	X	X			1	M	-	\$8.69	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0985	W/C SEAT LIFT MECHANISM	X	X	X			1	5 Y	\$232.90	-	-	-	
E0985 KU	W/C SEAT LIFT MECHANISM	X	X	X			1	5 Y	\$235.90	-	-	-	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>
E0985 RR	W/C SEAT LIFT MECHANISM	X	X	X			1	M	-	-	\$23.29	\$17.47	
E0985 RR KU	W/C SEAT LIFT MECHANISM	X	X	X			1	M	-	-	\$23.59	\$17.69	<a href="#">Refer to Alaska Medicaid KU Billing Guidance</a>

# Capped Rental 13 Month Rental Periods

- ▶ Capped Rental reimbursement methodologies are identified in the Social Security Act, Section 1834(a)(7).
- ▶ Alaska Medicaid will follow 13 month capped rental policies and procedures for rental items newly dispensed on/after January 1, 2020.
- ▶ Currently dispensed items receiving rental reimbursement are not affected by this change.
- ▶ Rented items not deemed Capped Rental items are not affected by this change.
- ▶ Capped rental items, when covered, are rented to a beneficiary for a period of continuous use not to exceed 13 months, at which point the beneficiary takes over ownership of the equipment.
- ▶ Some capped rental items may be purchased. The department will review the length of need for items and their cost before authorizing payment for rental or purchase. (7 AAC 120.225)



# Capped Rental Fee Schedule Methodologies

- ▶ **Capped rental items (other than power wheelchairs):** CMS calculates the fee schedule amount based on 10 percent of the base year purchase price. This is the fee schedule amount for months 1 thru 3. Beginning with the 4<sup>th</sup> month, the fee schedule amount is equal to 75 percent of the monthly fee schedule amount paid in the first three rental months.
- ▶ **Capped rental power wheelchairs:** CMS calculates the fee schedule amount based on 15 percent of the base year purchase price. This is the fee schedule amount for months 1 thru 3. Beginning with the 4<sup>th</sup> month, the fee schedule amount is equal to 40 percent of the monthly fee schedule amount paid in the first three months.

# Reimbursement Methodologies for Capped Rental Item Purchase

- ▶ **Rent to Purchase:** Ownership of the equipment must be transferred to the beneficiary after 13 months of rental.
- ▶ **Purchase of capped rental items (other than power wheelchairs):** DME suppliers may request purchase versus rental of items for non-dually eligible beneficiaries. If a beneficiary is Medicare eligible, DME suppliers must follow the Medicare requirements for requesting purchase vs. rental of capped rental items. The department will review the length of need for items and their cost before authorizing rental or purchase. If approved for purchase, reimbursement may not exceed 10 times the 1<sup>st</sup> month rental fee as indicated on the DMEPOS fee schedule or DMEPOS Interim fee schedule. If rental reimbursement was issued prior to a purchase authorization, reimbursement may not exceed 10 times the 1<sup>st</sup> month rental fee minus any and all rental payments.
- ▶ **Purchase of capped rental power wheelchairs:** DME suppliers may request purchase versus rental of items for non-dually eligible beneficiaries. If a beneficiary is Medicare eligible, DME suppliers must follow the Medicare requirements for requesting purchase vs. rental of capped rental items. The department will review the length of need for items and their cost before authorizing rental or purchase. If approved for purchase, reimbursement may not exceed the 1<sup>st</sup> month rental fee divided by 0.15. If rental reimbursement was issued prior to a purchase authorization, reimbursement may not exceed the 1<sup>st</sup> month rental fee divided by 0.15 minus any and all rental payments.

# Requesting and Billing Capped Rental Items

- ▶ When service authorizations are required, providers requesting to dispense a new capped rental item on or after January 1, 2020 must indicate the first 3 months of rental with an “RR” modifier and months 4 through 13 with an “RR” as the primary modifier and a “KJ” as the secondary modifier.
- ▶ Claims submitted for months 4 through 13 without the appropriate “KJ” modifier in the second position will be denied. Please note, claims for items dispensed prior to January 1, 2020 are not affected by this change.
- ▶ Service authorization numbers must be included on claims, when applicable.

# Billing Capped Rental Item Example #1

Procedure code E0250, *Hospital bed, fixed height, with mattress,*

- ▶ **Capped rental only for a total of 13 months:**
  - ▶ Months 1 through 3 are billed with an RR modifier and reimbursed at \$78.70 per month.
  - ▶ Months 4 through 13 are billed with RR and KJ modifiers and reimbursed at \$59.03 per month.
  - ▶ Ownership is transferred to the beneficiary on the first day of the 14th month.
  - ▶ Total reimbursement for the capped rental for 13 months rental is \$826.35.
- ▶ **Purchase with no rental payments made:**
  - ▶ Purchase of the capped rental item was approved without any rental periods.
  - ▶ Total reimbursement for the capped rental item as a direct purchase is \$787.00, or 10 times the amount of the 1st month rental rate indicated on the appropriate fee schedule.
- ▶ **Purchase after rental payments made:**
  - ▶ Months 1 through 3 were reimbursed at \$78.70 for each rental month totaling \$236.10.
  - ▶ At month 4, a service authorization was approved for purchase of the item.
  - ▶ Reimbursement for the purchase of the hospital bed was \$550.90. This was calculated at a purchase of \$787.00 minus rental payments of \$236.10.

# Billing Capped Rental Item Example #2

Procedure code K0848, *Grp 3 Power Wheelchair, sling/solid seat/back, patient weight capacity up to and including 300 pounds*

- ▶ **Capped rental only for a total of 13 months:**
  - ▶ Months 1 through 3 are billed with an RR modifier and reimbursed at \$793.71 per month.
  - ▶ Months 4 through 13 are billed with RR and KJ modifiers and reimbursed at \$317.48 per month.
  - ▶ Ownership is transferred to the beneficiary on the first day of the 14th month.
  - ▶ Total reimbursement for the capped rental for 13 months rental is \$5,555.97.
- ▶ **Purchase with no rental payments made:**
  - ▶ Purchase of the capped rental item was approved without any rental periods.
  - ▶ Total reimbursement for the capped rental item as a direct purchase is \$5,291.40, or the monthly rental fee identified for months 1 through 3 (\$793.71) divided by 0.15.
- ▶ **Purchase after rental payments made:**
  - ▶ Months 1 through 3 were reimbursed at \$793.71 for each rental month totaling \$2,381.13.
  - ▶ At month 4, a service authorization was approved for purchase of the item.
  - ▶ Reimbursement for the purchase of the power wheelchair was \$2,910.27. This was calculated at a purchase rate of \$5,291.40 minus rental payments of \$2,381.13.

# Unaltered Invoice

- ▶ Final purchase invoice showing supplier cost, minus any discounts, contractual or otherwise.
- ▶ Where no information on the original invoice is removed, erased, redacted, omitted, or otherwise modified so that the copy submitted to the department is anything other than an exact copy of the original invoice received by the enrolled provider from the provider's supplier.
- ▶ Legible markings made by an enrolled provider on the original invoice as part of the enrolled provider's normal business practices will not result in the department viewing an invoice as altered, if the markings
  - ▶ Do not remove, erase, redact, omit, or otherwise modify the invoice in a way that results in any of the information on the original invoice becoming illegible; and
  - ▶ Appear on both the original invoice and the copy submitted to the department; or
  - ▶ Shows a price other than the final price paid by the enrolled provider.
  - ▶ {7 AAC 145.420(o)}

# Invoice Example #1

**DME Supplier**


123 Main Street P: 907.555.1212 Example@example.com  
 Anchorage, AK 99501 F: 907.555.2121 DMESupplier1@alaska.com

Bill To: DME Provider #1 P: 907.555.1111 Invoice #: 123456  
 Address: 321 Sesame Street, Anchorage, AK 99105 F: 907.555.2222 Invoice Date: 1/6/2020  
 Email:

Invoice For: December Shipment

Item #	Description	Qty	Unit Price	Discount	Price
A6217	Non-sterile gauze >16 Sq in	180	\$ 0.50	25%	\$ 89.75
A6230	Gauze, >48 Sq in, water/saline	350	\$ 1.00	35%	\$ 349.65
					\$ -
	Invoice Subtotal		\$		439.40
	Tax Rate				0.00%
	Sales Tax		\$		-
	Other		\$		-
	Deposit Received				
	<b>TOTAL</b>		\$		439.40

Make all checks payable to DME Supplier.  
 Total due in <#> days. Overdue accounts subject to a service charge of <#>% per month.



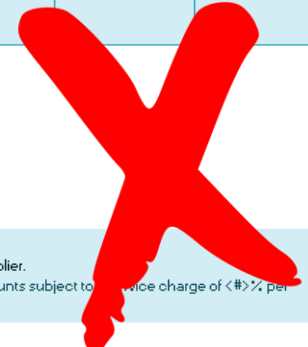
[Redacted]

Bill To: DME Provider #1 P: 907.555.1111 Invoice #: [Redacted]  
 Address: 321 Sesame Street, Anchorage, AK 99105 F: 907.555.2222 Invoice Date: [Redacted]  
 Email:


Invoice For: [Redacted]

Item #	Description	Qty	Unit Price	Discount	Price
A6217	Non-sterile gauze >16 Sq in	180	\$ 0.50	25%	\$ 89.75
[Redacted]	[Redacted]	[Redacted]	\$ [Redacted]	[Redacted]	\$ [Redacted]
					\$ -
	Invoice Subtotal		\$		[Redacted]
	Tax Rate				[Redacted]
	Sales Tax		\$		-
	Other		\$		-
	Deposit Received				
	<b>TOTAL</b>		\$		[Redacted]


Make all checks payable to DME Supplier.  
 Total due in <#> days. Overdue accounts subject to a service charge of <#>% per month.



# Invoice Example #2

 **DME Provider #1**

123 Main Street P: 907.555.1212 Example@example.com  
Anchorage, AK 99501 F: 907.555.2121 DMEProvider1@alaska.com


 Bill To: Recipient Name #1 P: 907.555.1111 Invoice #: 123456  
Address: 321 Sesame Street, Anchorage, AK 99105 F: 907.555.2222 Invoice Date: 1/6/2020  
Email:

Invoice For: December Product

Item #	Description	Qty	Unit Price	Discount	Price
A6217	Non-sterile gauze >16 Sq in	50	\$ 0.50	0%	\$ 25.00
A6230	Gauze, >48 Sq in, water/saline	25	\$ 1.00	0%	\$ 25.00
					\$ -
				Invoice Subtotal	\$ 50.00
				Tax Rate	0.00%
				Sales Tax	\$ -
				Other	\$ -
				Deposit Received	
				<b>TOTAL</b>	\$ 50.00

Make all checks payable to DME Provider #1.  
Total due in <#> days. Overdue accounts subject to a charge of <#> per month.

Do not pay. Products being billed to Medicaid



- Do not create an ‘invoice’ showing ‘charges’ from a provider to a recipient.
- This example does not indicate the provider’s cost of the items but demonstrates what the provider intends to bill Medicaid for the items.



# Invoice Example #3

## Shipping Invoice/Receipt

### DME Provider #1

123 Main Street P: 907.555.1212 Example@example.com  
 Anchorage, AK 99501 F: 907.555.2121 DMEProvider1@alaska.com

Bill To: Recipient Name #1 P: 907.555.1111 Invoice #: 123456  
 Address: 321 Sesame Street, F: 907.555.2222 Invoice Date: 1/6/2020  
 Somewhere Else, AK 99105 Email:

Invoice For: December Product

Item #	Description	Qty	Unit Price	Discount	Price
A9999CG	Shipping	1	\$ 47.50	0%	\$ 47.50
					\$ -
			Invoice Subtotal		\$ 47.50
			Tax Rate		0.00%
			Sales Tax		\$ -
			Other		\$ -
			Deposit Received		
			<b>TOTAL</b>		\$ 47.50

Make all checks payable to DME Provider #1.  
 Total due in <#> days. Overdue accounts subject to service charge of <#>% per month.

11/8/2018 USPS **Priority Mail** 9A 09... Label **\$13.60**  
 Printed

**Recipient address**  
 Jane Doe  
 123 Main Street  
 Somewhere, AK 99999


**Sender address**  
 DME Provider #1  
 123 Main Street  
 Anchorage, AK 99501

**Purchased on**  
 11/8/2018 12:37 PM

**Shipment Information**  
 Large Package  
 24.0 in x 13.0 in x 14.0 in,  
 16 lb

**Tracking Number**  
 9A 096435

**Total** \$13.60  
**Priority** \$13.60  
**Mail**



# Pricing Research B4088

- ▶ B4088 is identified in the Healthcare Common Procedure Coding initiative as a Gastrostomy/jejunostomy tube, low-profile, any material, any type, each
- ▶ Research requests for this item included invoices for purchased products.
- ▶ Purchased products were identified as ‘kits’ and therefore were shown to be a higher cost than listed on the DMEPOS fee schedule.
- ▶ As the ‘kit’ includes additional items, how would suppliers adjust their billing of other supplies to ensure max quantities are not exceeded if we were to allow for a ‘kit’ at a different rate?

# Upcoming Information & Changes

- ▶ Oxygen Supply Equipment, clarification of payment methodologies and billing guidance
- ▶ Requests for Wheelchairs and their Options & Accessories. Ensure Medical Necessity is documented in the supplier's records - It's more than the diagnosis!
- ▶ Equipment replacement guidelines and clarifications
- ▶ CPAP clarification and guidance

# Next WebEx

Wednesday, April 8, 2020

10:00 a.m.

(Link will be sent via RA message)

If you have any comments, questions, or topics you would like to see addressed in future WebEx meetings, please email them to [Karen.benson@alaska.gov](mailto:Karen.benson@alaska.gov)