DME Quarterly Update

Wednesday, April 8, 2020

Quarter 2 Agenda

- Meeting guidelines
- Recap from Quarter 1 meeting
- April 1, 2020 Medicare fee schedule
- Oral/Enteral Nutrition
- Incontinence
- Wheelchair options, accessories, replacement chairs and parts
- Billing
  - Medicare PAR for power wheelchairs
  - Max quantities
  - Bilateral items
- COVID-19 Q&A

Meeting Guidelines

- Be positive. This meeting is not intended to call out mistakes, past issues, or negatively highlight any particular person or provider.
- Generalize. We will not be able to discuss specific service authorizations, claims, members, staff, etc. but can discuss standard processes, changes, etc.
- Respect. All viewpoints are honored and we will consider all comments, questions and suggestions.

Recap from Q1 Update meeting

- Was to be discussed during this quarterly meeting:
  - Oxygen supply equipment, clarification of payment methodologies and billing guidance – deferred to 3rd quarter
  - CPAP, BiPAP clarification and guidance – deferred to 3rd quarter
  - Wheelchairs and options & accessories, replacement guidelines and clarifications – partial clarifications and guidance this meeting

Quarter 2 Fee Schedule

- No Medicare rate changes for Q2.
- Changes to AK Medicaid fee schedule
  - Enteral
  - Wheelchair
  - Continuous Glucose Monitors, Blood Ketone test strips

Oral/Enteral

- New Enteral Certificate of Medical Necessity form available
  - Should fulfill the majority of medical record needs without obtaining/submitting additional information
  - Will be made a required form, potentially by June 1, 2020

MEMBER INFORMATION	ORDERING PROVIDER INFORMATION
Member Name: ____________ *(Last, First, MI)*	Ordering Provider's Name: ____________
Alaska Medicaid Member ID: ____________	Provider Medicaid ID or NPI: ____________
Date of Birth *(MM/DD/YY)*: ____________ Age: ______	Phone Number: ____________ Ext. ______

Type of Request ☐ Initial Request ☐ Revised Prescription – Authorization ID ____________ ☐ Prescription Renewal

CLINICAL INFORMATION *(This section **MUST** be completed by the ordering physician, physician assistant, or nurse practitioner.)*

Date of Last Physician Visit Related to Nutrition	ICD-10 Diagnosis Codes *(Enter all Dx related to need for enteral nutrition therapy.)*

Answer Questions 1 – 6 *(Y = Yes, N = No)*

Question	Answer
1. *INITIAL REQUESTS ONLY* – Are enteral products needed to discharge from hospital setting?	Y or N *Discharge Date:* ________
2. *UNDER 21 YRS* – Consultation with registered dietician or licensed nutritionist in last 12 months? ** Consultation may be through the Alaska WIC Nutrition Program or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.*	Y or N *Consult Date:* ________
3. Do member's medical records demonstrate a non-function or disease of the structures that normally permit food to reach the small bowel or disease of the small bowel which impairs digestion and absorption of an oral diet? *May be anatomic condition or motility disorder.*	Y or N
4. Do member's medical records demonstrate that the member is unable to obtain sufficient caloric and protein intake from any regular, liquefied, or pureed foods?	Y or N
5. Are enteral needs the result of a temporary condition that will be fully resolved within 3 months?	Y or N
6. *ORAL REQUESTS* – Does member reside in an assisted living home (ALH) or long-term care (LTC) facility?	N or ALH or LTC

Height	Weight	Target Weight

Daily Caloric Intake Requirements

Total Calories: ____________ Calories from Ingested Foods/Liquids: ____________ Calories from Enteral: ____________

Route of Administration *(Check all that apply.)*	Number of Monthly Refills *(1 - 11 Months)*
☐ Syringe ☐ Gravity ☐ Pump * ☐ Oral * If requested, medical records must support necessity of pump over syringe/gravity method.	

REQUESTED NUTRITIONAL PRODUCTS *(This section **MUST** be completed by the ordering physician, physician assistant, or nurse practitioner.)*

Nutritional Product Description	Calories / Quantity	Frequency *(i.e., per day, per hour)*

Supply Needs and/or Additional Feeding Instructions

ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN / PHYSICIAN ASSISTANT / NURSE PRACTITIONER

A physician, physician assistant, or nurse practitioner who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be

CONDUENT

MEMBER INFORMATION

Member Name: ____________________ *(Last, First, MI)*

Alaska Medicaid Member ID: ____________________

Date of Birth *(MM/DD/YY)*: ____________ Age: ______

ORDERING PROVIDER INFORMATION

Ordering Provider's Name: ____________________

Provider Medicaid ID or NPI:

Phone Number: ____________________ Ext. ________

CONDUENT USE ONLY

Service Authorization ID

☐ Approved as requested
☐ Approved as modified
☐ Denied

Start Date End Date

Authorizing Agent Signature/Date

____

SERVICING PROVIDER INFORMATION

Provider Name: ____________________

Provider Medicaid ID: ____________________

Address: ____________________

____

Phone Number: ____________________ Ext. ________

Fax Number: ____________________ Ext. ________

Requester Name:

REQUESTED SERVICES OR ITEMS *(To Be Completed by Supplier)*

	Procedure Code	Mod	HCPCS Description	Total Quantity Requested	Quantity Dispensed *	Dispense Date	Authorized Yes	Authorized No	Quantity Approved	Comments
1										
2										
3										
4										
5										

** A maximum 30 days of enteral supplies may be dispensed prior to a service authorization approval IF the request is submitted within one (1) business day of dispensing AND is for:*

- *an initial request for a member discharging from an inpatient status OR*
- *a revised prescription for a formula categorized under a different HCPCS code than previously authorized (i.e., approved for B4159 but new formula is under B4161) OR*
- *a revised prescription with an increase in caloric intake.*

The above requests will be approved with a retroactive start date reflecting the dispense date. All other requests (i.e., transferring providers, annual renewals, dispensed requests not submitted timely) will be approved with a start date no earlier than the request review date or the expiration date of the existing authorization being renewed, whichever is later.

ATTESTATION, SIGNATURE AND DATE OF SUPPLIER

I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering physician/physician assistant/nurse practitioner specified in this form, and that these exact services or items listed in this form will be supplied to the specified member. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

____________________ Signature of Supplier

____________________ Date

Oral/Enteral, cont'd.

- B4161 CG
  - We have been made aware that Peptamen and Peptamen 1.5 should not be claimed under B4161 or B4161 CG. We are looking at these products and further information will be forthcoming on the next fee schedule.
  - Peptamen and Peptamen 1.5, by NDC, are listed as B4153
  - Does not affect Peptamen Jr. under B4161 CG
- B4088 CG
  - Effective April 1, 2020, a rate of $121.56 has been established for a Gastro/Jejuno Tube Kit. Must supply full kit in order to submit claim for B4088 CG.
  - If providing a full kit, you may request service authorization amendments to update B4088 to B4088CG with the same quantities, allowances, expiration dates, etc.
  - Amendments may only be retroactive to April 1, 2020.

Incontinence CMN Revisions

MEMBER INFORMATION	PROVIDER INFORMATION
Member Name: ____________ *(Last, First, MI)*	Ordering Provider's Name: ____________
Alaska Medicaid Member ID: ____________	Provider Medicaid ID or NPI: ____________
Date of Birth *(MM/DD/YY)*: ________ Age: _____ Sex:	Phone Number: ____________ Ext. ________
*Height: ______ *(inches)* *Weight: ________ *(pounds)*	Prescription Start Date: ____________
Date of last visit related to incontinence: ____________	

SECTION A - CLINICAL INFORMATION *(This section MUST be completed by the attending physician, physician assistant, or nurse practitioner.)*

	Diagnosis Code	Diagnosis Description
ICD-10		
	Include ALL diagnoses to include the type of incontinence and the cause of the incontinence at a minimum.	

Estimated Length of Need *(# of Months)*: ________ *(99 = Lifetime)*

SECTION B - CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN

Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. Attach any supporting documentation as needed for further justification.

(This section may only be completed by the attending physician, physician assistant, or nurse practitioner within the scope of his or her specialty.)

Questions 1-7 below must be completed.

1. Is the individual at least three years of age and under 10 years of age and do medical records document that the recipient has not responded to, would not benefit from, or has failed bowel or bladder training? ☐ Yes ☐ No ☐ N/A
2. What is the individual's frequency of incontinence?
3. Provide a description of the individual's ability to manage incontinence independently or with assistance.
4. What is the individual's prognosis for controlling incontinence?
5. What is the individual's level of skin integrity and vulnerability to skin breakdown?
6. Is the individual prescribed diuretics or other medications that increase output? ☐ Yes ☐ No
7. Does the individual have any allergies to known product materials? ☐ Yes ☐ No

Provide additional medical justification, as it pertains to the member's specific diagnoses, indicating the medical necessity of the requested items. Attach any supporting documentation as needed. If requests are made for greater than current maximum quantities of items, additional medical justification **MUST** be submitted with this form to justify the need for greater than maximum quantities. Please see quantities listed on page 2 of the Certificate of Medical Necessity for Incontinence Supplies Instructions.

PLAN: *The plan should list each service or item specifically needed for the treatment of the member. Attach additional treatment information.* ***If "Other Qty" is completed****, you must provide* ***additional medical justification*** *for the higher quantity requested.*

** ***Please see current max quantity limits under the Certificate of Medical Necessity for Incontinence Supplies Instructions, page 2. For quantities requested under 'Other Qty' sections below, additional medical justification MUST be submitted with this form to justify the need for greater than maximum quantities.***

Daily Usage Supplies *(mark appropriate quantity)*:

Item	Quantity	Other Qty
Disposable Brief / Undergarment	○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6	Other Qty ___
Insert Pads *(used in briefs)*	○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6	Other Qty ___
Disposable Bed Pads	○ 1 ○ 2 ○ 3 ○ 4	Other Qty ___

Quarterly Usage Supplies *(mark appropriate quantity)*:

Item	Quantity
Reusable Bed Pads w/ or w/o Flaps	○ 1 ○ 2 ○ 3 ○ 4

Monthly Usage Supplies *(mark appropriate quantity)*:

Item	Quantity	Other Qty
Gloves *(per month)*	○ 100 ○ 200 ○ 300 ○ 400	Other Qty ___
Disposable Wipes *(each)*	○ 100 ○ 200 ○ 300 ○ 400 ○ 500	Other Qty ___
Disposable Wash Cloths *(each)*	○ 100 ○ 200 ○ 300 ○ 400 ○ 500	Other Qty ___

*May be based on recipient preference of up to 1000 wipes or 1000 wash cloths without requiring an updated prescription/CMN form.

Note to Supplier: If the packaging quantity is not the same as the 100/200/300/400/500 quantity selected, round to the nearest size packaging to avoid breaking open a package.

Monthly Skincare Supplies *(mark appropriate quantity)*: 1 Unit = One container *(bottle, tube, etc.)* regardless of size or volume.

These supplies are for incontinence treatment only and not for treatment of other areas of the body.

Current utilization requirements limit the following supplies to no more than 2 bottles, containers, etc. of any one product per month or combination of products. Requests for more than a total 2 products per month, regardless of the type of product or combination of products, will not be approved.

Choose only ONE (1) Option below

☐ 1 bottle Moisture barrier lotion/ointment/gel/cream

OR ☐ 2 bottles Moisture barrier lotion/ointment/gel/cream

OR ☐ 1 bottle Moisture barrier lotion/ointment/gel/cream AND 1 bottle Protectant Powder

OR ☐ 1 bottle Moisture barrier lotion/ointment/gel/cream AND 1 bottle Skin Cleanser

OR ☐ 1 bottle Protectant Powder AND 1 bottle Skin Cleanser

OR ☐ 1 bottle Protectant Powder

OR ☐ 2 bottles Protectant Powder

OR ☐ 1 bottle Skin Cleanser

OR ☐ 2 bottles Skin Cleanser

Wheelchairs, parts, options & accessories

- Identified incorrect claims for wheelchair parts, options, accessories when new wheelchair is being dispensed
  - Codes, such as replacement hand rims code E2205, are being submitted on claims for newly dispensed wheelchairs.
  - When dispensing new wheelchairs, replacement codes may not be used to upgrade wheelchairs from their standard no cost options.
- Service authorization requests will need to identify all parts/pieces of the wheelchair to be dispensed, including make and model numbers of major components
- Ensure medical necessity is identified for all parts/pieces. Medical necessity is identified in the medical record, not solely based on PT evaluation.
- Ensuring all diagnoses are identified in the medical record allow for more accurate review of initial wheelchairs and any requested upgrades
- Fee schedule will reflect all wheelchair parts, pieces, options and accessories will require service authorization
- Effective date to be determined and sent via RA message

Billing: Medicare crossover wheelchairs

- Identified inconsistencies with service authorizations when Medicare PAR is involved
  - PAR must identify all parts and pieces of the wheelchair to be dispensed to the individual, not what is believed will be covered by Medicare
  - All options, including any/all upgrades should be included in Medicare request
  - Medicare determination must be submitted with service authorization request
  - Ensure correct Medicare billing when dispensing a wheelchair that is above what Medicare has deemed as medically necessary
    - Can obtain additional Medicare billing information
      - https://med.noridianmedicare.com/web/jddme/topics/upgrades
      - https://med.noridianmedicare.com/web/jddme/dmepos/pmds;jsessionid=78765E67D18702991A80E24A379101C1

Tip to Avoid Pay Delays: Billing > Max

- When billing quantities over the maximum allowed per the fee schedule:
  - Validate the maximum allowed quantity before dispensing
  - There must be a service authorization (SA) on file for the excess quantities
  - Don’t forget to include the SA # on your claim!
- Billed quantities that are over the maximum allowed amounts will suspend for State review.
  - If there is no SA # submitted on the claim, the line will be denied even if an SA exists.
  - If quantities above the allowed amount are dispensed without an authorization and the line is denied, you may rebill up to the max allowed amount for reimbursement.
  - You may also appeal for the full amount dispensed. The appeal must be submitted with the prescription order and substantiating medical records to be considered.

Tip to Avoid Pay Delays: Billing Bilateral

- When billing for bilateral items (stockings, wheelchair tire replacements, etc.):
  - Use the appropriate LT and RT modifiers
  - Bill each side on a separate claim line

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01	03	20	01	03	20	12		A6531	LT				A	60	00	1		NPI	1234567890
01	03	20	01	03	20	12		A6531	RT				A	60	00	1		NPI	1234567890

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01	03	20	01	03	20	12		A6531	LT	RT			A	120	00	2		NPI	1234567890

COVID-19 Temporary Guideline review

- Oral/Enteral Nutrition and Supplies
  - Dispensing 30-day supply at time of initial prescription without approved SA is allowed. This will be standard from this point forward as identified on the Enteral CMN discussed previously.
  - Prescribers can follow telehealth guidelines for any face to face requirements. While telehealth may not be appropriate in each and every situation/case, it is an avenue that can be pursued to meet F2F requirements for renewals.
  - Changes to formulas only, no change in HCPC or caloric intake, may dispense according to the prescription change.
  - Changes involving HCPC code and/or increase in caloric intake, dispense according to prescription change and submit for service authorization amendment.
  - If you have specific expiring service authorizations that fall outside of the previously issued temporary guidelines, email detailed information to Karen, Tracy and Krystal for additional guidance

Oxygen, ventilators, nebulizers, tracheostomy, urological supplies, burn garments, cranial remolding devices

- We understand some providers are having a difficult time obtaining medical documentation.
- Should submit service authorization with the documentation you have.
- If needed, additional information will be requested to finalize the service authorization determination and we understand this may take additional time.
- May continue to dispense products as needed during pendency of the service authorization request.

Incontinence supplies

- May dispense up to a 90-day supply, if recipient agrees.
- No more than 2 A6250 products may be dispensed per month, unless currently dispensing under an unexpired service authorization that permits higher quantities.
- Once current service authorizations containing higher allowances for A6250 expire, no more than 2 A6250 products may continue to be dispensed. This is regardless of the quantities previously authorized on the expired authorization. Higher quantities will not be re-authorized.

Delivery/shipping of products during COVID-19 temporary guidelines

- If delivering, may avoid recipient signature by documenting previously determined delivery date, verifying through a window, phone call, etc. that recipient or other are available to receive product from door. Delivery driver should document how verified someone is home to receive product in place of recipient signature.
- May ship within 50 miles radius of the supplier's closes location.

COVID-19 Q&A – What are your questions?