CONDUENT

Enteral Nutrition Certificate of Medical Necessity, Page 1 of 2

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)*

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.)*

☐ Syringe ☐ Gravity ☐ Pump * ☐ Oral

***** If requested, medical records must support necessity of pump over syringe/gravity method.

Number of Monthly Refills *(1 - 11 Months)*

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 made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____ _____

Signature of Ordering Physician / Physician Assistant / Nurse Practitioner Date

Authorization does not guarantee payment. Payment is subject to member's eligibility. Check that identification card is current before rendering services.

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		Quantity Approved	Comments
							Yes	No		
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

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CONDUENT

Enteral Certificate of Medical Necessity Instructions

Submission Requirements: This Certificate of Medical Necessity (CMN) must be completed to request services and must bear the signatures of the professionals who, by signing the form, attest that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements. **Submit all CMN requests directly to Conduent, the fiscal agent**, by fax at 907.644.8131 or by mail at Conduent Service Authorization, PO Box 240808, Anchorage, AK 99524-0808.

Enteral Nutrition Certificate of Medical Necessity, Page 1

Member Information

Member Name: Enter the member's last name, first name and middle initial.

Alaska Medicaid Member ID: Enter the Alaska Medicaid Member ID number.

Date of Birth: Enter the member's date of birth using the calendar feature or a MM/DD/YY format.

Age: Enter the age of the member.

Ordering Provider Information

Ordering Provider's Name: Enter the ordering provider's last name, first name, and middle initial.

Provider Medicaid ID or NPI: Enter the ordering provider's Medicaid ID or NPI number.

Phone Number & Ext.: Enter the ordering provider's contact phone number and extension.

Type of Request: Select the option that most appropriately reflects the reason for the request.

Clinical Information *This section **must** be completed by the attending physician, physician assistant, or nurse practitioner.*

Date of Last Physician Visit Related to Nutrition: Enter the date the patient was last seen by their primary care provider regarding nutritional needs.

Answer Questions 1-6: Circle the answer that most accurately reflects the member's condition, current status, and medical records as applicable.

Height: Enter the member's height in inches. Measurement must be within last 12 months.

Weight: Enter the member's weight in pounds. Measurement must be within the last 12 months.

Target Weight: Enter the member's target weight in pounds.

ICD-10 Diagnosis Codes: Enter the all ICD-10 diagnosis codes related to the need for enteral nutrition therapy.

Daily Caloric Intake Requirements: Specify the member's daily calorie requirements in terms of *total calories*, *calories from ingested foods or liquids*, and *calories from enteral products.*

Route of Administration: Check the route(s) of enteral administration being requested.

Number of Monthly Refills: Specify the number of monthly refills prescribed in addition to the initial fill.

Requested Nutritional Products *This section **must** be completed by the attending physician, physician assistant, or nurse practitioner.*

Nutritional Product Description: Enter the specific nutritional product or type of product being prescribed to the member.

Description may include specific brand, formula components, concentration, etc.

Calories / Quantity: Specify the number of calories or quantity prescribed for each nutritional product.

Frequency: Specify the frequency each prescribed nutritional product should be administered (per day, per 2 hours, etc.).

Supply Needs and/or Additional Feeding Instructions: Use this area to specify any specialized supply needs, abnormal quantity requests, and any additional feeding instructions needed for proper administration of the product(s) being prescribed.

If higher than allowed quantities are being requested, medical records or other documentation demonstrating medical necessity of excessive quantities must be attached to support the request.

Refer to the current DMEPOS fee schedule for allowed quantities at http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp.

Attestation, Signature, and Date of Physician/Physician Assistant/Nurse Practitioner: Enter signature of the physician/physician assistant/nurse practitioner submitting the CMN request and date signed. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.

Forward this form to: Conduent Service Authorization, PO Box 240808, Anchorage, AK 99524-0808

Authorization does not guarantee payment. Payment is subject to member's eligibility. Check that identification card is current before rendering services.

Enteral Nutrition Certificate of Medical Necessity, Page 2

Member Information

Member Name: Enter the member's last name, first name and middle initial.

Alaska Medicaid Member ID: Enter the Alaska Medicaid Member ID number.

Date of Birth: Enter the member's date of birth using the calendar feature or a MM/DD/YY format.

Age: Enter the age of the member.

Ordering Provider Information

Ordering Provider's Name: Enter the ordering provider's last name, first name, and middle initial.

Provider Medicaid ID or NPI: Enter the ordering provider's Medicaid ID or NPI number.

Phone Number & Ext.: Enter the ordering provider's contact phone number and extension.

Servicing Provider Information

Provider Name: Enter the supplying provider's organization name.

Address: Enter the supplying provider's address.

Requester Name: Enter the name of the requesting individual that may be contacted if additional information is needed.

Provider Medicaid ID: Enter the supplying provider's Medicaid ID number.

Phone Number & Ext.: Enter the supplying provider's contact phone number and extension, if applicable.

Fax Number & Ext.: Enter the supplying provider's fax number and extension, if applicable.

Requested Services or Items

Procedure/Drug Code: Enter the procedure/drug code for the item requested.

Mod: Enter any applicable modifier codes for the requested item.

HCPCS Description: Enter the procedure code description of the requested item.

Total Quantity Requested: Enter the total requested quantity of the item to be dispensed during the span of the prescription. This total should include all quantities dispensed and not dispensed.

Quantity Dispensed: Enter the quantity of the item that has already been dispensed to the member. If products have not been dispensed, leave blank or enter "0".

Dispense Date: If *Quantity Dispensed* is > 0, enter the date the item was dispensed to the member.

Attestation, Signature, and Date of Supplier: Enter signature of the supplying professional submitting the CMN request. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.

Submission Note

Supporting medical records demonstrating medical necessity must accompany any requests for quantities exceeding Alaska Medicaid maximum allowable quantities as defined on the current Alaska Medicaid DMEPOS fee schedule.

Enteral Service Authorization Amendments

The below types of enteral prescription changes **do not** require a service authorization amendment. In both scenarios, providers must maintain appropriate documentation in the member's record and dispense according to the revised prescription.

- Prescriptions lowering the member's daily caloric requirement
- Prescriptions changing the brand of formula that would otherwise be categorized under the same HCPCS code and quantity as previously authorized.

All other changes to an approved enteral service authorization or requests for additional services or items must be requested through the Conduent Service Authorization department.

Forward this form to: Conduent Service Authorization, PO Box 240808, Anchorage, AK 99524-0808