# Prosthetics and Orthotics Regulations Effective June 2, 2019
# Durable Medical Equipment Regulations Effective July 2, 2019
# Frequently Asked Questions

**What is the compliance criteria for E0601 (CPAP device)?**

Compliance criteria has not changed for this code. Prior to dispensing, a service authorization (SA) is required. If authorization is given, it is initially provided for 3 months during which time the recipient must use the equipment for a minimum of 4 hours per night on 70% of nights during a consecutive 30 day period. The physician must review and validate the results prior to prescribing the equipment for additional months use. Centers for Medicare and Medicaid Services (CMS) compliance requirements must be followed. This has not changed with the new regulations.

**What is the compliance criteria for E0470 (Respiratory assist device)?**

Compliance criteria has not changed for this code. Prior to dispensing, a SA is required. CMS compliance requirements must be followed.

**Medicare allows the purchase of some items identified as rental items if justified by the length of need. Is this an option with Medicaid?**

If a provider is seeking purchase of durable medical equipment identified as a rental item on the fee schedule, the provider may request, via SA, purchase approval for the item. The department will evaluate the length of need and item cost before authorizing purchase on a rental item.

**How will Conduent be advising suppliers on whether a recipient is already receiving services from another supplier or when the last time they received an item that now has a maximum quantity restriction, such as a cane or walker?**

Provider may contact Provider Inquiry at 800.770..5650, option 1, 1, 1, or 907.644.6800, option 1, 1 to request information on whether or not a specific recipient is eligible to receive items such as canes or walkers.

**If we have a current SA for a specified number of units per month and that SA is valid through 12/31/2019, is the recipient still authorized under that SA until it expires?**

Yes, if a current SA is on file, it will not be affected by the change in regulations.

**We noticed that some waiver items are now identified on the new Medicaid DMEPOS Fee Schedule as code S5199. Will there continue to be a waiver fee schedule for items like wheelchair ramps and lift chairs under code T2029? Are items under S5199 now covered under the general Medicaid program, as opposed to just the waiver program?**

Codes for waiver services have not changed. S5199 by definition is a personal care item, NOS: this code should be used very infrequently as most DME items are associated with a more appropriate HCPCS code.

**7 AAC 120.200(q) and (s) require documentation in the medical record to substantiate the answers on the incontinence certificate of medical necessity (CMN) and will only pay if the enrolled prescriber completed a face-to-face examination of the recipient not more than six months before the beginning of services. Does this mean we must now have a copy of file of the qualifying chart notes when previously we were only required to have the signed CMN?**

A valid prescription order must include the date of the face-to-face examination and the prescriber portion of the CMN should provide the information necessary to substantiate the answers on the incontinence CMN. If the CMN does not substantiate the medical necessity of incontinence products, providers will need additional medical record information, such as chart notes on file.

**If HCPCS code A4335 is NDC coded, why is there no set pricing on the fee schedule and why would this item versus items under A6250 (creams, lotions, powders, etc.) require a SA?**

As A4335 is a miscellaneous incontinence supply code for which an NDC list has not been established, claims are paid at the unaltered final purchase invoice price plus 20%. The department may set a rate based on an NDC code product identifier and may require the identifier to be submitted on claims. To request pricing research to facilitate a set rate for a specific NDC code, please complete and submit a pricing research request. A4335 requires a SA due to being a miscellaneous supply code where A6250 is limited to creams, lotions, powders, etc.

**Codes A6530-A6539 now indicate quantities allowed of either 2 or 4 or current NCCI rules. Is that per month? Per Year?**

Quantity limits for compression stockings apply to a 3 month period. Quantities above listed limits require a SA.

**The SA requirement has been removed for the majority of T codes. How can we protect ourselves as the suppliers? If an individual were to bring the same prescription to two different suppliers, the only thing currently stopping another supplier from delivering supplies is the SA that exists.**

Suppliers may contact Provider Inquiry to determine if the individual is currently eligible to receive the supplies and is not receiving them from a different supplier.

**Does a patient have the ability to request a higher quantity of T codes or A codes for incontinence items?**

Requests for over the maximum units of T or A incontinence codes will continue to go through the SA request process.

**What happens when a recipient receives a replacement for a broken part and requests another replacement before the minimum time has elapsed?**

Providers may go through the SA process to replace the broken or damaged item, including submitting a description/reason the part was damaged or broken. If the SA is denied, the provider and/or individual may go through the appeals process to request replacement of the item.

**For complex rehab chairs, it is stated they can be replaced every 3 years or current NCCI rules. What is the NCCI rule for these chairs? Five years?**

Regulations state the department may pay for replacement items if replacement is necessary to replace an item that has been in continuous use by the recipient for the item's reasonable useful lifetime and has not required replacement of the product within the immediate three years due to abuse or neglect of the product. As different items vary in terms of their useful lifetime, each request for replacement is reviewed on a case by case basis.

**I understood the fee schedule was to reflect current Medicare rates, but the posted fee schedule does not match the current Medicare rates.**

The fee schedule that was posted with the regulations is the same fee schedule that was used during the public notice period as the package must remain together without changes once it goes through its final adoption phases. That posted fee schedule was based on 2017 rates. The fee schedule soon to be posted that will reflect the most current Medicare rates and are available for dates of service on or after June 2, 2109.

**What do I do if my cost to purchase and dispense an item is more than what is listed on the fee schedule?**

For state-based rates, you may request the department to research the rate by submitting a completed Pricing Research form. The department will research the item to determine if the rate should be revised. Revised rates will be listed on an interim or next quarterly updated fee schedule.

**What is the difference between a state-based and Medicare-based rate?**

Medicare-based rates are set by CMS, updated and published quarterly. State-based rates are rates set by the department for codes where CMS has not set a specific rate. State based rates are determined using a pricing methodology set in regulation.

**If we have a current SA that is approved for items either over the capped quantity listed in the fee schedules, or are no longer covered by Medicaid, will these items/quantities be covered until the authorization expires, or will they no longer be reimbursed if billed after 6/1/19?**

In general, SA for over the capped quantity will be honored. For questions on specific items no longer covered by Medicaid, please provide specific recipient/item information for review and specific answer. In general, most items will be covered through the authorization or until 100% of the purchase cost has been paid.

**Prescriptions now require the date of the face to face examination for all medical supplies. Is the supplier required to obtain that date on items that previously and currently do not require a SA?**

All prescriptions for newly requested medical supplies, medical equipment, prefabricated off-the-shelf orthotics and related items and services must contain the date of the face-to-face examination.

**Is the supplier required to also have a copy of the clinical record from the prescriber for that face to face encounter, or does the date supplied by the prescriber on the prescription or CMN serve as an attestation that it exists?**

The date of the face-to-face on the prescription should suffice.

**Delivery and shipping previously was paid without any attachments if under $50 (although that information had to be on file in an audit or if requested). Is that still the case under the new regulations?**

Yes, that is correct.

**Please clarify the signature requirement for shipping—does this mean that the supplier can no longer utilize the least costly method of shipping which is standard USPS mail to the recipient's home or post office box (no signature required)?**

When the shipping cost submitted to the department exceeds $50, documentation must include the recipient's signature with the date of receipt and should continue to be the most cost effect method of shipping. Shipping via USPS does have a 'signature required' option.

**For capped rental items, is the supplier required to obtain a new prescription for the final month of the capped rental, which is now 13 months, or like CMS, will the length of need of 'lifetime' or '99' suffice in order to bill out the final month and transfer ownership of the item to the recipient?**

New prescriptions are not required to ensure a 13 month of rental is paid. Prescriptions, with all pertinent information, are required prior to the start of services and in the cases of capped rentals cover all 13 months.

**Is my understanding correct that all rented DME will now require two CMN and two SAs because the regulations now state a prescription cannot exceed one year and SAs cannot exceed one year? This is not in line with Medicare, which allows the original CMN and SA to cover the final 12th and 13th months of rental.**

Capped rental items do not require two CMNs, prescriptions, or SAs. A valid prescription that is less than one year old and fulfills all requirements that define a valid prescription are required prior to the item or service being provided.