Alaska Medicaid Provider Billing Manual

Durable Medical Equipment, Medical Supplies, and Related Services (DME)

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About This Manual

The Department of Health (DOH) is the state agency designated to administer the Alaska Medical Assistance program, which includes:

- Medicaid
- Denali KidCare (DKC)
- Chronic and Acute Medical Assistance (CAMA)

Unless otherwise specified, references to the Alaska Medical Assistance program or Alaska Medical Assistance mean Medicaid, DKC, and CAMA. References to Alaska Medicaid, or Medicaid, mean only Medicaid and DKC.

This manual, *Durable Medical Equipment, Medical Supplies, and Related Services,* is to be used by enrolled medical suppliers, respiratory therapists, and home infusion therapy providers in conjunction with

- Professional Claims Management
- General Program Information

Updates to this manual will be necessary from time to time as federal and state medical assistance regulations are adopted. As updates are made, each affected segment of the manual will be annotated with the date of the change. Providers will be informed of these updates by remittance advice messages and announcements on the Alaska Medicaid Health Enterprise. Previously published manuals are available upon request.

Thank you for your participation in the Alaska Medical Assistance program and for the services you provide.

Legal Authority

The Durable Medical Equipment (DME) program is governed by the following:

- 42 CFR 440
- 7 AAC 120.200 – 7 AAC 120.245
- 7 AAC 120.399
- 7 AAC 145.420

Revision History

Revision Date	Revision Summary
7/1/2022	Department of Health rebrand | updated hyperlinks | added Pneumatic Compression Devices article | added Appendices A-C | updates for consistency

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Provider Enrollment

The following enrollment information is specific to medical suppliers, respiratory therapists, and home infusion therapy providers. For general enrollment instructions and guidelines, refer to General Program Information.

Provider Participation Requirements

Provider Participation Requirements for Home Infusion Therapists

In addition to the general conditions for participation identified in General Program Information, home infusion therapists must:

- Have and maintain a valid business license issued under AS 43.70 and 12 AAC 12.
- Hold an active pharmacy license under AS 08.80.
- Meet the guidelines for pharmacies and pharmacists under 12 AAC 52.400 – 12 AAC 52.440.
- Be enrolled in Medicare.
- Meet all participation requirements for a Medical Supplier and maintain a separate Medical Supplier enrollment.
- Complete, sign, and submit a Home Infusion Therapy Addendum.

7 AAC 120.245(a)

Provider Participation Requirements for Medical Suppliers

In addition to the general conditions for participation identified in General Program Information, a durable medical equipment (DME) provider must:

- Have and maintain a valid business license issued under AS 43.70 and 12 AAC 12.
- Be enrolled in Medicare.
- Comply with federal certification standards under 41 CFR 424.57(c).

7 AAC 120.200(a)

Provider Participation Requirements for Respiratory Therapists

In addition to the general conditions for participation identified in General Program Information, respiratory therapists must:

- Hold an active national registry number and certificate from the National Board for Respiratory Care (NBRC).
- Enroll individually and as part of a durable medical equipment (DME) supplier group.

7 AAC 120.235(a)

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Provider Participation Responsibilities for Medical Suppliers

Providers of durable medical equipment (DME) must:

- Verify that the recipient is eligible to receive the product. Refer to Recipient Eligibility Verification in General Program Management.
- Furnish orientation and training to the recipient regarding the proper use of the item. Upon request, providers must submit proof of this training to Alaska Medicaid.
- Maintain proof of receipt for items supplied to recipients. Upon request, providers must submit proof of receipt to Alaska Medicaid.
- Document and maintain records of a recipient's request for a refill, including the quantity of items that the recipient requests and the recipient possesses.
- Supply no more than what the recipient needs for a 30-day period.
- Accept returns of a substandard item that does not function in a manner that meets the prescribed need or specifications.
- Upon request, provide proof, in the form of copies of letters, logs, or signed notices, that the recipient has been supplied with the item's warranty information.

In addition to the requirements listed above, medical suppliers must review the continued medical necessity of DME, or supplies billed to Alaska Medicaid at least annually. More frequent reviews may be required depending on the nature of the item prescribed. Medical suppliers repairing items must attest to the continued medical necessity of the product being repaired.

7 AAC 120.200(b), (l-m)

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Recipient Eligibility

All references to recipient mean an individual who is eligible for and receiving assistance under Alaska Medicaid.

Eligibility Codes

The Department will pay an enrolled medical supplier, home infusion therapy, or respiratory therapy provider for covered services provided to a recipient who is eligible for Alaska Medicaid under one of the following eligibility codes:

Eligibility Codes: DME, Home Infusion Therapy, and Respiratory Therapy Series	
Code	**Category**
11	Pregnant Woman (Alaska Healthy Baby Program)
20	No Other Eligibility Codes Apply
21	Chronic and Acute Medical Assistance (CAMA) Coverage Only
24	LTC (300 %) Institutionalized
30	Adults with Physical and Developmental Disabilities (APDD) Waiver – Special LTC
31	APDD Waiver
34	APDD Waiver – Adult Public Assistance (APA)/Qualified Medicare Beneficiary (QMB) Eligible
40	Alaskans Living Independently (ALI) Waiver – Special LTC
41	ALI Waiver
44	ALI Waiver – APA/QMB
50	Child under 21 and not in state custody (including subsidized adoptions)
51	Child under 21 and in state custody (including Title IV-E Foster Care)
52	4-month Post-MAGI Medicaid eligibility (increased spousal support)
54	Supplemental Security Income (SSI) Disabled Child
69	Medicare Premium Assistance – APA/QMB
70	Intellectual and Developmental Disabilities (IDD) Waiver
71	IDD Waiver
74	IDD Waiver – APA/QMB
80	Children with Complex Medical Conditions (CCMC) Waiver
81	CCMC Waiver
91	Individualized Supports Waiver (ISW) – Special LTC
92	ISW
93	ISW – Pregnant Woman
94	ISW – APA/QMB Eligible

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DME Services

Alaska Medicaid reimburses enrolled providers for medically necessary services for eligible recipients when delivered, ordered, or prescribed by a provider within the scope of the provider's license or certification.

Services rendered based on a prescription, order, or referral are reimbursable only if the prescribing, ordering, or referring provider is enrolled as an Alaska Medicaid provider.

7 AAC 120.200(b)(1)(A), 7 AAC 120.310(c)

Travel for Medical Care

Alaska Medicaid covers transportation and accommodation services when travel is required to receive non-emergent, medically necessary services.

For additional information about non-emergent transportation, including how to request a service authorization, refer to Arranging Patient Travel.

Medicaid-Covered Services

Durable Medical Equipment and Supplies

Alaska Medicaid covers durable medical equipment (DME), medical supplies, prefabricated off-the-shelf orthotics, and related items and services if the item(s) or service(s) are:

- Prescribed by a physician, physician assistant, or advanced practice registered nurse enrolled in Alaska Medicaid and acting within the scope of their license.
- Prescribed after a face-to-face examination related to the primary reason the recipient requires DME within six months of the start of services.
- Appropriate for use in the recipient's home, school, and community.
- Not provided by, or under arrangements made by, a home health agency.
- Given a service authorization, if necessary. Refer to Service Authorization in this section.
- Dispensed or provided under a valid prescription order. Refer to Prescription Order in this section.
- Dispensed up to a 30-day supply within each 22-day period.
- Reviewed annually at a minimum for continued medical necessity.

More costly DME may be covered if the provider submits documentation with the claim demonstrating that a less expensive product is not available to meet the medical needs of the recipient. For more information, refer to Pricing for Services and Supplies with Established Rates in this section.

7 AAC 120.200(b), (s), 7 AAC 145.420(i)

Labor and Repair Parts

Alaska Medicaid covers labor and repair parts for damaged items if all warranties are expired, the cost of repair is less than half of the cost of a new item, the repair has a minimum 30-day warranty, and repair

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parts are dispensed or provided under a valid prescription order. The provider billing for repairs must provide the following documentation:

- A statement signed by the recipient or the recipient's authorized representative that describes the cause for and nature of the repair.
- A description of the item being repaired and its serial number, if available.
- The beginning and end dates of warranty coverage, if available.
- Documentation for labor charges that includes the amount of time spent on the repair, rounded up to the nearest quarter hour, and the hourly rate charged for the repair.
- An itemized list of parts used in repair and associated costs.

Alaska Medicaid covers shipping costs from the manufacturer to the provider for customized DME repair and replacement parts that are specialized or unique to a recipient's equipment and for which the final unaltered purchase invoice price exceeds $250. Refer to Unaltered Final Purchase Invoice in this section.

Note: The shipping method used must be the most cost-effective method available.

7 AAC 120.200(b), 7 AAC 145.420(f)

Purchase of DME

Alaska Medicaid may cover the purchase of new or used durable medical equipment (DME), medical supplies, prefabricated off-the-shelf orthotics, or related items and services. In order for the item to become the property of the recipient, the provider must transfer ownership of the item, including any warranty, to the recipient and provide appropriate documentation if the item was previously used.

Alaska Medicaid considers capped rental items to be purchased in full after 13 months of continuous rental or after 100 percent of the purchase price has been paid, whichever occurs first. On the first day after an item is considered purchased, ownership information, including warranties and title, must be transferred to the recipient.

Alaska Medicaid may pay medical suppliers for used or refurbished DME at a rate of no more than 75 percent of the current established rate for rental or purchased items if the following criteria are met:

- The recipient must acknowledge in writing, and the provider must maintain the written acknowledgment, that the recipient is receiving used or refurbished equipment.
- The provider must bill with modifier UE for used or refurbished equipment and retain the product serial number in the dispensing record and provide to Alaska Medicaid upon request.
- The used or refurbished equipment provided must
  - Be clean and sanitized,
  - Meet the current needs of the recipient,
  - Be close to the manufacturer's suggested specifications for a newly purchased piece of equipment, and
  - Be able to withstand at least three years of use.
- If the previously used equipment needs to be replaced before the standard replacement limit has been met, the provider must replace the item with a new or used piece of equipment at no charge.

7 AAC 120.215(a),(d),(i), 7 AAC 120.225(d-e)

Purchase or Rental of DME for Recipients in Facilities

Alaska Medicaid may cover the purchase or rental of durable medical equipment (DME) for a recipient in a skilled nursing facility (SNF) or intermediate care facility (ICF) if the item is medically necessary for the recipient's preparation for discharge or for the actual discharge to home. A rental or purchase may not be arranged sooner than 30 days before the scheduled discharge and will be authorized only if the

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equipment is not provided by the SNF/ICF. Alaska Medicaid may also cover trial use of rental equipment for preparing a recipient for discharge.

7 AAC 120.200(c)

Rental of DME

Before authorizing rental of durable medical equipment (DME), Alaska Medicaid will review the length of need for the item and its cost. Medical suppliers are reimbursed by rental period and the rental fee paid by Alaska Medicaid covers any necessary repairs, return shipping, and maintenance. Except for continuous rentals, rentals are capped at 13 months or when 100 percent of the purchase price has been paid, whichever occurs first. If Alaska Medicaid decides to purchase the item instead of continuing to rent it, providers will be reimbursed up to the remaining portion of the full purchase price, not rental plus the full purchase price. When total rental payments reach the purchase price, repair is covered after 60 days or when the warranty expires, whichever is later.

Ownership of the equipment must be transferred to the beneficiary after 13 months of a capped rental.

Alaska Medicaid may cover the rental of used or refurbished DME at a rate of no more than 75 percent of the established rate for purchased items if the following criteria are met:

- The recipient must acknowledge in writing, and the provider must maintain the written acknowledgment, that the recipient is receiving used equipment.
- The provider must include modifier UE that distinguishes used equipment from new equipment and the equipment's serial number on the claim.
- The used or refurbished equipment provided must be clean and sanitized.
- The used or refurbished equipment provided must meet the current needs of the recipient and be
  - Without defect,
  - Close to the manufacturer's suggested specifications for a newly purchased piece of equipment, and
  - Be able to withstand at least three years of use.
- If the item needs to be replaced before the standard replacement limit has been met, then the provider must replace the item with a new or used piece of equipment at no charge.

7 AAC 120.225(b), 7 AAC 120.225(e)

Rental Period

A rental period begins when the recipient first receives the rental item and is not affected by an interruption of less than 60 consecutive days including the days remaining in the rental month in which the use stops. If an interruption continues beyond that time period, the provider must obtain a new prescription order and submit a new service authorization (SA) request before the new rental period begins. Alaska Medicaid covers the rental month in which use stops but will not make an additional payment until the new rental period begins. Rental items for which an SA has been received, but for which no payment is made, do not apply toward a capped rental period. A 13-month continuous rental period for capped rental items is not interrupted when:

- The existing continuous rental equipment is modified to accommodate a change in the recipient's medical needs. The rental period for the existing equipment will continue and a new rental period for the added equipment will begin, if applicable.
- Rental equipment is replaced with different, but similar, equipment billed with the same HCPCS code.
- There is a temporary or permanent change in the recipient's residence.

7 AAC 120.215(e-f), 7 AAC 120.230

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Replacement of Items

Alaska Medicaid covers the purchase or rental of durable medical equipment (DME) or prefabricated off-the-shelf orthotic to replace an item that has been in continuous use by the recipient for the item's reasonable useful lifetime and

- Is no longer covered by the manufacturer’s warranty.
- Is lost or irreparably damaged.
- Has not already been replaced within the immediate three years due to abuse or neglect of the product.
- Is replaced with a like item.
- If the original item was rented, continues renting the replacement.

7 AAC 120.220

Administrative Expenses

The following costs are considered administrative expenses and are included in the payment for items and services:

- Telephone responses to questions
- Mileage
- Travel expenses
- Travel time
- Setting up an item
- Installation
- Preparation and maintenance of necessary records
- Orientation and training regarding the proper use of the item

7 AAC 120.200(k)

Continuous Oxygen

Alaska Medicaid covers continuous oxygen provided to a recipient living in skilled nursing facility or intermediate care facility if the facility is not authorized to provide continuous oxygen and for which a service authorization has been issued.

7 AAC 120.200(c), 7 AAC 120.210(b)(10)

Delivery and Shipping Costs

Providers may be reimbursed for the reasonable and necessary direct costs of delivering or shipping items from the dispensing provider to the recipient or from the recipient to the dispensing provider for the repair of recipient owned equipment if:

- The recipient resides outside the municipality where the business of the enrolled servicing provider is located.
- The item is unavailable from an enrolled provider where the recipient resides.
- The cost of shipping home infusion pharmaceutical products exceeds 40 percent of the sum of the per diem rate for the number of days represented in the shipment.
- The final unaltered purchase invoice price exceeds $250 for a specialized or unique item.

Note: The shipping method used must be the most cost-effective method available.

Expedited, next day, rush, or delivery charges resulting from the use of a shipping method other than the most cost-effective method available may be covered if the ordering prescriber submits medical justification for the expedited delivery and the request is approved by Alaska Medicaid.

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Alaska Medicaid may cover shipping costs due to the recipient traveling for medical, educational, or vocational reasons. Documentation from the prescribing physician supporting the recipients' reason for travel must be submitted with the claim to include estimated duration of travel.

Alaska Medicaid may cover shipping costs from the manufacturer to the provider for customized DME repair and replacement parts that are specialized or unique to a recipient's equipment and for which the final unaltered purchase invoice price exceeds $250. Refer to Unaltered Final Purchase Invoice in this section.

Alaska Medicaid may cover shipping costs if a recipient resides within a municipality that has an enrolled provider if the dispensing provider submits documentation attesting that the recipient has attempted to acquire the item from the locally enrolled provider and the item was not available.

Multiple shipments on the same date of service for a single recipient must be consolidated into a single shipment where possible. Where shipping consolidation is not feasible, submit the total shipping charges for all shipments on a single claim line and attach all shipping receipts to the claim.

7 AAC 120.200(i), 7 AAC 145.420(k)(4)

Enteral and Oral Nutritional Products

Alaska Medicaid covers enteral and oral nutritional products prescribed by the attending physician, physician assistant, or advanced practice registered nurse and not provided by, or under arrangements made by, a home health agency or hospice program. Enteral or oral nutritional products must be certified as medically necessary using the Certificate of Medical Necessity - Enteral Nutrition form to indicate that sufficient caloric or protein intake is not obtainable through regular, liquefied, or pureed food.

7 AAC 120.240

Home Infusion Therapy Services

Home infusion therapy services are covered when prescribed by a physician, physician assistant, or advanced practice registered nurse and reviewed at least every 60 days to determine the ongoing medical need for the service. Home infusion therapy services must be appropriate for use in the recipient's home, school, or community. Enrolled home infusion therapy providers may employ or contract with a registered nurse to perform home infusion nursing services who has provided documentation of training and skills in the following:

- Intravenous insertion techniques
- Parenteral administration
- Line and site management
- Proper use of equipment

A home infusion therapy period begins the day home infusion therapy services are initiated and ends the day home infusion therapy services are discontinued and not anticipated to begin again. If home infusion therapy services resume after a therapy period has stopped, those services are considered to be a part of a new therapy period.

7 AAC 120.200(d), 7 AAC 120.245

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Incontinence Supplies

Alaska Medicaid covers disposable incontinence products including diapers, liners, underpads, reusable protective underpads, wipes, and washcloths for recipients three years of age and older if:

- The supplies are prescribed by an enrolled physician, physician assistant, or advanced practice registered nurse on a Certificate of Medical Necessity – Incontinence Supplies.
- The supplies meet national quality standards.
- The supplies accommodate a medical condition resulting in bladder or bowel incontinence.
- The recipient has not responded to, would not benefit from, or has failed bowel or bladder training.

There is a dispensing limit of 180 items for any combination of diapers, briefs, or pull-ups per recipient per month. For further clarification on which combinations of products may be dispensed within that 180-item limit, refer to Appendix C: Incontinence Policy Clarification.

Alaska Medicaid covers the following skincare items for a recipient experiencing bladder or bowel incontinence:

- skin sealant
- skin protectant
- skin moisturizer
- skin ointment
- skin cleanser
- skin sanitizer

The monthly allowance of skincare items may not exceed two combined units of A6250 per recipient per month regardless of product dispensed. SA requests for higher quantities are not permitted and will be voided.

Medical suppliers may request an SA for additional incontinence supplies, not including skincare products, beyond the covered amounts listed on the Alaska Medicaid DMEPOS Interim Fee Schedule. Refer to Service Authorization for Incontinence Supplies in this section.

7 AAC 120.200(g), (h), (p)

Respiratory Therapy Equipment, Supplies, and Assessment Visits

Alaska Medicaid covers respiratory therapy equipment, supplies, and assessment visits when provided by an enrolled respiratory therapist affiliated with a DME provider. A service authorization is required for respiratory therapy assessment visits for ventilator-dependent recipients. Respiratory therapy assessment visits must be certified as medically necessary using the Certificate of Medical Necessity (CMN) form.

Alaska Medicaid covers medical supplies or respiratory therapy assessment visits furnished to recipients receiving hospice care services, if the supplies or assessment visits are ordered by a physician as part of a written hospice plan of care and the physician reviews the recipient's continuing medical need for the supplies or visits, and are appropriate for use in the recipient's home, school, or community. Supplies and assessment visits are not eligible for payment for a recipient who is receiving hospice care services if the supplies or assessment visits are related to the treatment of the terminal illness that qualifies the recipient for hospice care or provided by or under arrangements made by the hospice program.

7 AAC 120.200(f), 7 AAC 120.205(c), 7 AAC 120.235

Skilled Nursing Services

Home infusion therapy providers may also provide skilled nursing services in a recipient's home if the total cumulative time of the visit is two hours or less; additional hours will be paid separately. Alaska Medicaid may pay a per diem amount if the skilled nursing visit is provided on the same day the recipient receives infusion therapy outside the home and a physician, physician assistant, or advanced practice

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registered nurse has ordered additional infusion therapy to continue in the home. One skilled nursing visit may also be covered for catheter insertion and patient instruction:

- At a hospital on the day before or the day of discharge from the hospital.
- On the day of surgery at a hospital-based infusion clinic or an ambulatory surgical center.

7 AAC 120.200(e)

Non-covered Services

The services listed below are not covered for medical suppliers, respiratory therapists, and home infusion therapy providers. This list is representative of non-covered services and procedures and is not intended to be all-inclusive. For additional non-covered services, refer to General Program Information.

- Durable medical equipment (DME) provided to a recipient in a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) or who is receiving hospice care services except as allowed by federal law
- Home infusion therapy services provided to a recipient:
  - In a hospital, SNF, or ICF
  - Receiving like services provided by or under arrangements by a home health agency
  - Receiving similar services during an outpatient visit at a hospital or facility on the same day
  - Receiving hospice care services
- The following services when provided by a home infusion therapy provider:
  - Routine servicing of an infusion device for equipment included in the per diem payment
  - Catheter care and maintenance identified as "not otherwise classified"
  - Nursing services only for insertion of a peripherally inserted central venous catheter (PICC) or a midline central venous catheter
  - Nursing services when same-day services are provided by a home health agency or at a hospital or facility during an outpatient visit
  - The following items, without a specific dosage timing or quantity:
    - Pain management infusion
    - Chemotherapy infusion
    - Total parenteral nutrition (TPN)
    - Hydration therapy
    - Antibiotic, antiviral, or antifungal therapy
    - Professional pharmacy services
  - Continuous insulin infusion therapy
  - After-hours care
  - Home injectable therapy
  - Dietitian services
  - Delivery or service to high-risk areas requiring escort or extra protection
  - High-technology registered nursing services
  - Infusion suite services
  - Home therapy enteral nutrition
  - Home administration of aerosol drug therapy
  - Home transfusion of blood products
  - Home irrigation therapy
- The repair of DME while the recipient is in a SNF or ICF
- Medical supplies or respiratory therapy assessment visits if the supplies or assessment visits are related to the treatment of the terminal illness that qualifies the recipient for hospice care or provided by or made under arrangements made by a hospice program
- Repair, return shipping, or preventive maintenance or service of DME that is already included in the rental fee

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- Repair, return shipping, or preventive maintenance or service of DME without documented medical necessity for the continued use of the item
- Medical supplies that are required under federal law to be provided at no cost to employees, including gloves, masks, and isolation gowns
- Medical equipment that Medicare has deemed medically unnecessary for the individual
- Respiratory therapy equipment provided by, or under arrangements made by, a home health agency or hospice program
- Enteral and oral nutritional products provided by, or under arrangements made by, a home health agency or hospice program
- Shipping costs related to recreational travel
- Labor and repair parts if the item is covered under a manufacturer's or supplier's warranty, or if the labor or parts are necessary to repair an item that needs repair because of a manufacturer's defect
- Labor and repair parts for a rented item: providers must ensure that a rented item functions as intended after the provider repairs or replaces the item.
- Purchase of items that require continuous rental
- A single upfront payment for the full cost of an item identified as a capped rental item
- Options, supplies, or accessories that are included in the monthly rental payment or covered by the manufacturer’s warranty

7 AAC 120.200(l), 7 AAC 120.205(b - g), 7 AAC 120.215(b-c), 7 AAC 120.225(g), 7 AAC 120.240(a), 7 AAC 120.245(d), 7 AAC 145.420(k)(4)

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Prescription Order

A prescription order for all durable medical equipment (DME), medical supplies, and related items and services must contain the following:

- Recipient's name and date of birth
- Item or service being prescribed
- ICD diagnosis code
- Quantity of item or service being prescribed
- Directions or instructions for proper use of the item or service including the frequency of use, if applicable
- Duration or estimated length of need for the item
- Enrolled prescribing provider's signature and order signature date
- Number of refills, if applicable
- Date of the face-to-face examination

A prescription order may be part of the Certificate of Medical Necessity (CMN), as long as all of the components listed above are included. A DME provider may not prepare the clinical information and clinical assessment of need portion of a CMN that contains a prescription order.

A prescription order, or prescription order that is part of a CMN, will be accepted for no more than one year from the signature date forward. Retrospective prescription orders, with current day signature, may be considered on a case-by-case basis.

The prescriber's hardcopy original or authenticated digital signature from an electronic health record system must be made and affixed to the prescription order or prescription order that is part of the CMN. A signature stamp or a copy of a signature will not be accepted as part of a valid prescription order even if affixed to the prescription order by the prescriber. Alaska Medicaid will accept a prescription order or CMN with the prescriber's signature received via fax.

7 AAC 120.200(t), (v-x)

Face-to-Face Encounter

Prior to the receipt of a prescription order, a face-to-face examination as defined under 42 CFR 440.70(f) and CFR 410.38 must occur no more than six months prior to the start of services and must be related to the primary reason that the recipient requires the DME.

7 AAC 120.200(s)

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Service Authorization

Providers must obtain a service authorization (SA) to receive reimbursement for:

- Items, services, and supplies listed as requiring an SA on the Alaska Medicaid DMEPOS Interim Fee Schedule and Home Infusion Therapy Fee Schedules.
- Items and supplies that are prescribed for use outside of their intended purpose.
- Capped or continuous rental of durable medical equipment (DME) listed as requiring an SA on the Alaska Medicaid DMEPOS Interim Fee Schedule.
- Medical supplies that exceed the maximum units per timeframe or 30-day limit.
- Customized or optimally configured DME.
- Items that are identified by miscellaneous HCPCS codes.
- Respiratory therapy assessment visits for ventilator-dependent recipients.
- Home infusion therapy services.
- Enteral and oral nutritional products.
- Purchase of DME, medical supplies, prefabricated off-the-shelf orthotics, or related items and services for a recipient in a skilled nursing facility (SNF) or intermediate care facility (ICF).
- Continuous oxygen for a recipient in a SNF/ICF.
- Purchase of DME, medical supplies, prefabricated off-the-shelf orthotics, or related items and services if the charge to Alaska Medicaid is over $1,000.
- Medical supplies and services if the charge to Alaska Medicaid is over $1,000 for a single claim or for a 30-day supply.
- DME, medical supplies, prefabricated off-the-shelf orthotics, or related items and services requiring an SA listed on the CMS “Required Prior Authorization List.”
- Optimally configured power wheelchairs that require payment under capped rental rules where the DME provider requests direct purchase.
- DME provided to a Medicare-Medicaid dual eligible recipient that Medicare has denied.
- Replacement item prior to the end of the item’s useful lifetime.
- Complex rehabilitative manual or power wheelchair options and accessories with KU modifiers if the supplier would like to be reimbursed corresponding KU Modifier rates.

In order to obtain an SA, providers must submit to Conduent a completed Certificate of Medical Necessity (CMN), Certificate of Medical Necessity – Incontinence, or Certificate of Medical Necessity – Enteral, as appropriate, accompanied by a prescription order from the enrolled ordering physician, physician assistant, or advanced practice registered nurse and if the recipient is under 21 years of age, documentation that the item or service is necessary to treat, correct, or ameliorate a defect, condition, or physical or mental illness. A prescription order may be part of the CMN, as long as all of the components of a prescription order are included. A DME provider may not prepare the clinical information and clinical assessment of need portion of a CMN that contains a prescription order. Refer to Prescription Order in this section.

In addition to the requirements listed above, an SA request for miscellaneous items or optimally configured DME, must include, if available for the item, manufacturer information, the item description or number, the global trade item number (GTIN), the suggested list price, and the serial number.

Note: A recipient’s medical record must contain a copy of the signed CMN and all supporting documentation.

For additional information on SA policy, refer to Appendix A: Service Authorization Policy Guidance.

7 AAC 120.200(u-v), 7 AAC 120.210(b),(d),(g)

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Capped Rentals and KJ Modifiers

When service authorizations (SA) are required, providers requesting to dispense a new capped rental item, 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.

SA requests submitted for months 4 through 13 without the appropriate “KJ” modifier in the second position will be denied.

SA numbers must be included on claims, when applicable.

Complex Rehabilitative Power Wheelchairs and KU Modifiers

When requesting certain complex rehabilitative wheelchair options and accessories, DME providers may request a service authorization (SA) for HCPCS codes with a KU modifier as indicated below:

- Covered HCPCS / KU modifier combinations are specifically identified on the Alaska Medicaid DMEPOS Interim Fee Schedule.
- Wheelchair options and accessories using the KU modifier must be furnished in connection with a Group 3 complex rehabilitative power wheelchair (HCPCS codes K0848 – K0864).
- When a complex rehabilitative wheelchair base is validated in the beneficiary file and that specific wheelchair needs replacement parts, use of the KU modifier is appropriate.

An SA is required on claims for wheelchair options and accessories submitted with a KU modifier even if the HCPCS code without the KU modifier does not require an SA. The KU modifier MUST be identified on the SA approval.

SAs and/or claims will be denied if the submitted HCPCS / KU modifier is not specifically identified on the Alaska Medicaid DMEPOS Interim Fee Schedule with a specific rate and/or there is no indication the recipient owns the appropriate equipment that requires a replacement part or supply.

If an SA has been approved for a complex rehabilitative wheelchair and accessories fitting the criteria above **AND** you have not yet provided the wheelchair to the recipient, you may request an SA amendment to add the HCPCS / KU modifiers. Providers must submit the original approved SA (first page), any additional documentation needed to support the change, if necessary, and provide, in specific detail, the requested changes. Use a cover sheet, along with the original approved SA, clearly indicating the request to add the KU modifier to specific HCPCS codes.

Dressings and Surgical Supplies

Quantities identified on the Alaska Medicaid DMEPOS Interim Fee Schedule are allowed quantities per wound. If the recipient has more than one qualifying wound, a service authorization (SA) is not required so long as the quantities dispensed per wound do not exceed the maximum allowed quantities. Suppliers must maintain appropriate medical documentation substantiating each wound, including appropriate diagnosis code, number, size, severity, and location of all wounds in the recipient’s file.

Dressings and surgical supplies that are part of a kit or supply allowance (e.g., enteral daily allowance or tracheostomy daily care kits) may not be authorized or billed separately. Supply quantities that exceed established kit contents must be requested on a CMN and include medical documentation substantiating the need for additional supplies.

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SA requests for HCPCS codes A4450, A4452, or A5120 that are being used in conjunction with:

- Ostomy, tracheostomy, or urological supplies must be submitted with an “AU” modifier.
- A prosthetic or orthotic must be submitted with an “AV” modifier.
- Surgical dressings must be submitted with an “AW” modifier.

Enteral Supplies

In order to obtain a service authorization (SA) for enteral supplies, providers must submit to Conduent a Certificate of Medical Necessity – Enteral Nutrition form completed by the recipient’s enrolled ordering physician, physician assistant, advanced practice registered nurse to include:

- The date of the recipient’s last physician visit related to nutrition.
- All diagnosis codes related to the need for enteral therapy.
- Clinical information including nutritional needs, route of administration, and needed duration *(refer to CMN form).*
- Requested nutritional products and specific supply needs.

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

- an initial request for a recipient 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 HCPCS code B4159 but new formula is under HCPCS code B4161) **OR**
- a revised prescription with an increase in caloric intake for a previously approved SA.

Enteral requests meeting the above conditions 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 SA being renewed, whichever is later.

Requests in Excess of Monthly Maximum Allowed Amounts

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 Interim Fee Schedule.

Requests for Enteral Supplies

Alaska Medicaid requires all items and services to be properly coded. Enteral feeding supply daily allowances are identified by HCPCS codes B4034 (Syringe fed), B4035 (Pump fed), and B4036 (Gravity fed) and include all supplies, except for the feeding tube and nutrients, required for the administration of enteral nutrients to the recipient for one day. When billing for enteral supplies, providers should bill these daily supply allowance codes (HCPCS codes B4034, B4035, or B4036). Separate billing for any daily enteral supply item, including an item using a specific HCPCS code, if one exists, or under miscellaneous code B9998 will be denied as unbundling.

7 AAC 120.205(i)

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Enteral Service Authorization Amendments

The below types of enteral prescription changes do not require an SA amendment. In both scenarios, providers must maintain appropriate documentation in the recipient's record and dispense according to the revised prescription.

- Prescriptions lowering the recipient'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 SA or requests for additional services or items must be requested through the Conduent Service Authorization department.

Incontinence Supplies

In order to obtain a service authorization (SA) for incontinence supplies, providers must submit to Conduent a Certificate of Medical Necessity – Incontinence Supplies form completed by the recipient's enrolled ordering physician, physician assistant, advanced practice registered nurse to include:

- ICD diagnosis code related to the cause of incontinence of the bladder, bowels, or both,
- ICD diagnosis code related to the type of incontinence,
- For recipients at least three years of age and under ten years of age, documentation that the recipient has not responded to, would not benefit from, or has failed bowel or bladder training,
- Prognosis for controlling incontinence,
- Name of each item to be dispensed,
- Frequency of incontinence,
- Duration of need,
- Diuretic or other medications that increase output,
- Products currently being used,
- Skin integrity, including vulnerability to skin breakdown,
- Measurements for product size,
- Quantity of each item,
- Known allergies to product materials, when applicable, and
- Description of ability to manage incontinence independently or with assistance.

Note: A recipient's medical record must contain a copy of the signed CMN and all supporting documentation.

7 AAC 120.210(c)

Pneumatic Compression Devices

Alaska Medicaid will consider approval of service authorization requests for pneumatic compression devices (PCDs) when determined to be medically necessary. PCDs coded as HCPCS E0650, E0651, and E0652 are used only in the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers. Reimbursement for these items is based on the guidelines and medical criteria found in the Pneumatic Compression Device Policy Guidance.

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Respiratory Assist Devices

Positive Airway Pressure (PAP) Device Documentation Requirements

Code	Initial Documentation Requirements	Months 1-3 (Trial Period)	Month 4 and After (Continued Coverage)
E0601	• Face-to-Face **before** Sleep Study • Sleep test: ○ 15 events/hour, min 30 events **or** ○ 5-14 events/hour, min 10 events **and** documentation of symptoms identified in LCD[1] • Recipient/caregiver received instruction on proper use and equipment care	Meet initial requirements	**Between 31st - 91st day** of PAP therapy, treating practitioner must conduct clinical re-evaluation; must include: • Face-to-face clinical re-evaluation • Evidence of required PAP device use adherence If re-evaluation occurs after 91st day of initiating therapy, but documents symptoms improved, coverage may be approved starting on the re-evaluation date. **Any dates between the 92nd day and the re-evaluation date are not covered.**
E0470	• Face-to-face and sleep study documentation from E0601 request • Recipient/caregiver received instruction on proper use and equipment care • **Documentation E0601 tried and proven ineffective per LCD[1]**; must include fit and pressure settings evaluations	Meet initial requirements	
	Used E0601 < 3 Months		
	• Does **not** require new face-to-face evaluation • Does **not** require new sleep test	*Continue original E0601 trial period*	**If > 30 days remained on E0601 trial period before E0470 substitution:** **Between 31st - 91st day** of PAP therapy, treating practitioner must conduct clinical re-evaluation; must include: • Face-to-face clinical re-evaluation • Evidence of required PAP device use adherence If re-evaluation occurs after 91st day of initiating therapy, but documents symptoms improved, coverage may be approved starting on the re-evaluation date. **Any dates between the 92nd day and the re-evaluation date are not covered.**
			If < 30 days remained on E0601 trial period before E0470 substitution: **Before the 120th day** of PAP therapy, treating practitioner must conduct clinical re-evaluation; must include: • Face-to-face clinical re-evaluation • Evidence of required PAP device use adherence If re-evaluation occurs on or after the 120th day of initiating therapy, but documents symptoms improved, coverage may be approved starting on the re-evaluation date. **Any dates between the 120th day and the re-evaluation date are not covered.**
	Used E0601 > 3 Months		
	• Requires new face-to-face evaluation • Does **not** require new sleep test	*Begin new trial period*	**Between 31st and 91st day** of **E0470** PAP therapy, treating practitioner must conduct clinical re-evaluation; must include: • Face-to-face clinical re-evaluation • Evidence of required **E0470** PAP device use adherence If re-evaluation occurs after 91st day of initiating E0470 therapy, but documents symptoms improved, coverage may be approved starting on the re-evaluation date. **Any dates between the 92nd day and the re-evaluation date are not covered.**
E0601 or E0470	If recipient failed initial trial period and requesting new trial period, initial documentation must also include: • Face-to-face re-evaluation must be completed to determine reason for failure to respond • Repeat Type 1 sleep test in facility-based setting		
E0471	Not appropriate if diagnosis is *Obstructive Sleep Apnea* per PAP LCD[1]. Refer to LCD for respiratory assist devices.		

[1] *Local Coverage Determination (LCD): Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718).*

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Claim Submission

Refer to Professional Claims Management for claim submission instructions and to CMS-1500 Claim Form Instructions for claim form completion instructions specific to Alaska Medicaid.

Billing for Durable Medical Equipment

The Alaska Medicaid DMEPOS Interim Fee Schedule lists HCPCS codes for covered items and services, service authorization or medical justification requirements, and the maximum allowable reimbursement rate. Providers should use these codes when submitting a claim.

Unpriced Covered Durable Medical Equipment (aka By Report)

Claims for durable medical equipment (DME) that are covered but unpriced on the Medicare DMEPOS Fee Schedule or Alaska Medicaid DMEPOS Interim Fee Schedule must have an unaltered final purchase invoice attached. 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 Unaltered Final Purchase Invoice below.

7 AAC 145.420(c)

Unaltered Final Purchase Invoice

A final purchase invoice that has legible markings on it will not be considered altered if the markings:

- Were made by the enrolled provider on the original invoice,
- Were made as part of their normal business practices,
- Do not remove, erase, redact, omit, or otherwise modify the invoice resulting in any information becoming illegible, and
- Appear on both the original invoice and the copy submitted to Alaska Medicaid.

Providers may make small annotations on an invoice to indicate which item(s) on the invoice corresponds to the submitted claim so long as the annotations do not remove, redact, omit, or otherwise modify the invoice. Submitted invoices must correspond to the exact item that was dispensed (e.g., same batch, same case, same serial number); invoices may not be for like items acquired before or after the specific item dispensed. The price on the invoice must match the final price paid by the enrolled provider.

7 AAC 145.420(o)

Delivery and Shipping Costs of Dispensed Items

When the submitted cost for delivering or shipping dispensed items to a recipient outside the community exceeds $50, the payment request supporting documents must include:

- Recipient’s name,
- Delivery address,
- Itemized list of products shipped/delivered detailing:
  - Product name,
  - Product identifier,
  - Quantity, and

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  - Serial number, when applicable.
- Shipment and delivery date,
- Recipient's signature with date of receipt, and
- Total charges minus all discounts, substantiated by a paid shipping invoice/receipt reflecting the actual payment.

Multiple Packages on Same Date of Service

If multiple packages are shipped on a single date of service, combine total shipping payments of all packages on a single claim line. Multiple claim lines for shipping on the same date of service will be denied as duplicate charges. Attach ALL shipping invoices/receipts for all packages to claim. Submitting one shipping receipt showing tally of all individual shipping receipts/charges for individual packages is not appropriate.

For additional policy guidance on shipping reimbursement, refer to Appendix B: Shipping Reimbursement.

7 AAC 120.200(j)

Shipping Costs for Customized DME Repair and Replacement Parts

A provider may request payment for the reasonable direct costs of delivery or shipping from the manufacturer to the provider for customized or optimally configured DME repair and replacement parts that are specialized or unique to a recipient's equipment or service and for which the final unaltered purchase invoice price exceeds $250. The unaltered final purchase invoice must include the purchase invoice for the replacement items or repair and shipping costs. If the unaltered final purchase invoice contains one or more items in addition to the repair or replacement part, Alaska Medicaid will pay for the shipping cost attributed to the repair or replacement part. The shipping cost attributed to the repair or replacement part will be calculated by dividing the shipping cost on the unaltered final purchase invoice by the number of items purchased and multiplied by the number of repair or replacement parts specific to the recipient's need.

7 AAC 120.200, 7 AAC 145.420(k)

Lateral and Bilateral Items

Many DME items or services require the provider to indicate which side of the body the item or service is being applied. Providers must submit these items or services with the appropriate LT (left) or RT (right) modifier. If billing bilateral items or services, submit each side on a separate claim line of the same claim.

National Correct Coding Initiative (NCCI)

In the event a recipient is prescribed a unique combination of durable medical equipment (DME) that is outside of standard practices, initial claims may receive one or more NCCI edits even if the provider obtained a service authorization prior to dispensing.

- Medically Unlikely Edits (MUE) – The quantity of items/services being billed generally exceeds medical necessity when provided concurrently.
- Procedure-to-Procedure Edits (PTP) – The items/services being billed generally exceed medical necessity if provided concurrently. This edit includes:
  - Billing for a primary item/service in addition to secondary item/services that are inherently included in the primary item/service.
  - Billing two or more similar items/services for the same anatomic structure or extremity that is used for the same purpose.

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Claim lines that receive an NCCI edit will be automatically denied. Providers are encouraged to review their claim for any errors and resubmit or adjust the claim as needed.

If the submitted claim is correct, providers may utilize the appeal processes and submit a First Level Appeal to Alaska Medicaid. NCCI appeals must include a prescription order for all items/services and medical records supporting medical necessity of all items/services concurrently.

*Providers should follow the entire first and second level appeal processes as needed.

Billing for Enteral Nutrition Products

Enteral nutrition products ("B" HCPCS codes) must be billed with the respective specific manufacturer product code dispensed and the correct corresponding HCPCS code and modifier as defined on the Alaska Medicaid DMEPOS Interim Fee Schedule.

7 AAC 145.420(m)

Billing for Incontinence Supplies

Briefs, Undergarments, Liners, Bed Pads, Gloves, and Wipes or Wash Cloths

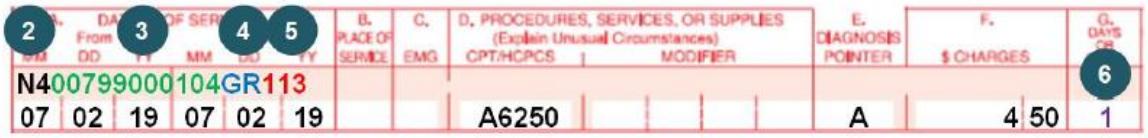
Incontinence supplies must be billed with the respective specific manufacturer product code dispensed and the correct corresponding HCPCS code and modifier, if applicable, as defined on the Alaska Medicaid DMEPOS Interim Fee Schedule. For further clarification on allowed quantities of incontinence products, refer to Appendix C: Incontinence Policy Clarification.

Skincare Supplies

When billing A6250, providers must submit corresponding NDC information according to National Uniformed Claim Committee (NUCC) CMS-1500 billing guidelines in addition to the HCPCS unit billing information. Failure to follow NDC billing guidance may impact reimbursements. Refer to the Procedure Code A6250 Payment Methodology Guidance for NDC examples.

Billing A6250 on a CMS-1500 Claim Form

1. Record the NDC information in the **shaded area** above the claim line in field 24.



2. The "N4" designation must be submitted at the beginning of any NDC submission.
3. Enter the 11-digit NDC of the actual product dispensed.
4. Enter the appropriate NDC unit qualifier, grams, or milliliters, for the product dispensed as "GR" or "ML".
5. Enter the NDC unit quantity, converted to grams or milliliters, of the product dispensed. Up to 3 decimal places may be used to indicate partial NDC units.
6. Enter the HCPCS unit quantity equivalent to the NDC unit quantity dispensed. Use the table below to determine NDC-specific conversion.

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Errors may be corrected by fully covering the incorrect information with white correction tape or fluid. If entering any information over the correction, ensure it is fully legible and in blue or black ink only. Errors that are lined through, but still visible, or covered with any color other than white correction tape or fluid, will cause a data error and the claim line will be denied.

7 AAC 145.420(m)

Billing for Home Infusion Therapy

When the recipient receives multiple administered therapies, providers must bill the appropriate per diem code and modifier for the second, third, or any subsequent concurrent therapy. Review the Home Infusion Therapy Services Interim Fee Schedule to review allowable codes and modifiers.

For drugs used in home infusion therapy, Alaska Medicaid will accept electronic pharmacy claims. Providers may not include compounding and dispensing fees unless the drugs are dispensed to a recipient in a long-term care facility.

7 AAC 120.245(c)

Billing Capped Rentals and KJ Modifiers

When a capped rental item is initially dispensed, submitted claims must identify 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.

Service authorization numbers must be included on claims, when applicable.

Billing for Dressings and Surgical Supplies

Quantities identified on the Alaska Medicaid DMEPOS Interim Fee Schedule are allowed quantities per wound. If the recipient has more than one qualifying wound, claims must be submitted with an appropriate diagnosis code for each current wound. For example, if the recipient has three separate wounds, three valid ICD-10 diagnosis codes must be reported—one for each wound.

Suppliers have the option to use modifiers “A1”–“A9” to further indicate that a particular item is being used as a primary or secondary dressing as well as to indicate the number of wounds on which that dressing is being used. If a dressing is not being used as a primary or secondary dressing on a surgical or debrided wound, the use of the “A1”–“A9” modifiers would be inappropriate.

Dressings and surgical supplies that are part of a kit or supply allowance (e.g., enteral daily allowance or tracheostomy daily care kits) may not be billed separately.

Claims for HCPCS codes A4450, A4452, or A5120 that are being used in conjunction with:

- Ostomy, tracheostomy, or urological supplies must be submitted with an “AU” modifier.
- A prosthetic or orthotic must be submitted with an “AV” modifier.
- Surgical dressings must be submitted with an “AW” modifier.

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Pricing Methodology

Durable Medical Equipment Pricing

Pricing for Services and Supplies with Established Rates

Alaska Medicaid reimburses medical suppliers for durable medical equipment (DME), medical supplies, prefabricated off-the-shelf orthotics, and related items and services to recipients physically located in Alaska at 100 percent of the amount listed on the current quarter's Medicare DMEPOS Fee Schedule.

Higher Rate Pricing

Alaska Medicaid may reimburse medical suppliers at a higher rate than the state-based rate listed on the Alaska Medicaid DMEPOS Interim Fee Schedule for more costly DME, medical supplies, prefabricated off-the-shelf orthotics, or related items and services if the recipient's medical condition substantiates the need and the documentation is submitted with the claim that demonstrates that a less expensive product is not available to meet the medical needs of the recipient. Providers may request a higher reimbursement by submitting a completed Alternate Reimbursement Rate Request form. Approved requests are reimbursed at the actual acquisition cost plus:

- 35 percent for actual acquisition costs under $5,000.
- 30 percent for actual acquisition costs of $5,000 or more.

7 AAC 145.420(j)

Pricing for Services and Supplies without Established Rates

Non-miscellaneous items and services that do not have an established rate on the current quarter's Medicare DMEPOS Fee Schedule or Alaska Medicaid DMEPOS Interim Fee Schedule or will be manually priced by Alaska Medicaid based on the submitted unaltered final purchase invoice price plus 35 percent, if the invoice cost is less than $5,000, or 30 percent, if the invoice cost is $5,000 or more, until a rate is set by CMS or Alaska Medicaid. A rate will be set for a covered, non-priced, non-miscellaneous HCPCS code when at least 10 claims have been paid and one or more claims have been paid to at least two different enrolled providers. The rate set for the code will be based on the following criteria:

Median unaltered final purchase invoice price under $5,000:

- Median price of the first 10 claims plus 35 percent.
- Median price of all claims paid for the item plus 35 percent if 15 or more claims are paid but claims have not been paid to at least two different enrolled providers for the HCPCS code.

Median unaltered final purchase invoice price $5,000 or more:

- Median price of the first 10 claims plus 30 percent.
- Median price of all claims paid for the item plus 30 percent if 15 or more claims are paid but claims have not been paid to at least two different enrolled providers for the HCPCS code.

When applicable, the maximum allowable rental rate for an un-priced covered item defined under a non-miscellaneous code is 10 percent of the rate determined above.

State-based rates established for a covered code that CMS has not issued a rate for may be published on the Alaska Medicaid DMEPOS Interim Fee Schedule. Providers may request formal research of state-

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based rates by using the Durable Medical Equipment/Prosthetics and Orthotics Price Research Request form. If Alaska Medicaid revises the HCPCS code rate, the established rate will not be retroactive and will apply to future dates of service only.

7 AAC 145.420(b-c), (e)

Pricing for Miscellaneous HCPCS Codes

Covered items submitted using a miscellaneous HCPCS code that do not have an established rate will be paid at the unaltered final purchase invoice price plus 20 percent. Alaska Medicaid will not set a generic rate for the HCPCS code but may at a future date set a rate based off the National Drug Code or other product identifier and require the unique identifier on the submitted claim. When applicable, the maximum allowable rental rate for an un-priced covered item defined under a miscellaneous code is 10 percent of the combined total of the purchase invoice price plus 20 percent.

7 AAC 145.420(d)

Pricing for DME Rentals Excluding Capped Rentals

Alaska Medicaid reimburses medical suppliers for durable medical equipment (DME) rentals of 30 days or more at the lesser of a monthly rental rate of 10 percent of the allowed purchase rate or the rental price listed on the Alaska Medicaid DMEPOS Interim Fee Schedule.

For a rental period that is less than 30 days, Alaska Medicaid reimburses medical suppliers at a monthly rental rate of 150 percent of the monthly fee, divided by the number of days in the month, times the number of days in the rental period. Payment may not exceed the monthly rate.

HCPCS codes defined as daily rental codes or with a specific daily rate identified on the Alaska Medicaid DMEPOS Interim Fee Schedule will be reimbursed at the lesser of the rental price listed on the Alaska Medicaid DMEPOS Interim Fee Schedule or the billed rental rate.

Rental reimbursements and any subsequent purchase reimbursement of the same item may not exceed the allowed purchase rate listed on the Alaska Medicaid DMEPOS Interim Fee Schedule. If an item, new or used, is rented for any period of time (i.e., trial period) and then purchased, Alaska Medicaid reimburses medical suppliers at 100 percent of the purchase rate listed on the Alaska Medicaid DMEPOS Interim Fee Schedule minus any prior rental reimbursements for the same item.

Example 1: A new item X has an established purchase rate of $500.

- The medical supplier rents a new item X to a recipient for three months to fulfill the recipient's initial assessment period.
  - Each rental month is reimbursed at 10 percent of the purchase rate, or $50, for a total of $150.
- After successful completion of the initial assessment period, the medical supplier submits a purchase request for the same item instead of continuing to rent the item to the recipient.
- The maximum allowed purchase rate for this item is $350 because the supplier has already been reimbursed for three rental months on this item.

Example 2: A new item Z has an established purchase rate of $1000. A used item Z will be reimbursed at no more than 75 percent of the established purchase rate or $750.

- The medical supplier rents a used item Z to a recipient for two months to fulfill the recipient's initial assessment period.
  - Each rental month is reimbursed at 10 percent of the purchase rate, or $75, for a total of $150.
- After successful completion of the initial assessment period, the medical supplier submits a purchase request for the same item instead of continuing to rent the item to the recipient.

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- The maximum allowed purchase rate for this item is $600 because the supplier has already been reimbursed for two rental months on this item and the item was a used item.

Pricing for DME Capped Rentals

Alaska Medicaid follows CMS Medicare capped rental reimbursement methodologies (as identified in the Social Security Act, Section 1834(a)(7)), for capped rental items. In general, 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.

Capped Rental Payment 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 through 3. Beginning with the 4th 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 through 3. Beginning with the 4th 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

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 1st month rental fee as indicated on the Alaska Medicaid DMEPOS Interim Fee Schedule. If rental reimbursement was issued prior to a purchase authorization, reimbursement may not exceed 10 times the 1st month rental fee minus all rental payments.

For example, HCPCS code E0250, *Hospital bed, fixed height, with mattress*, has been designated as a capped rental item. The following are examples of reimbursement scenarios:

- 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, an SA 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.

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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 1st month rental fee divided by 0.15. If rental reimbursement was issued prior to a purchase authorization, reimbursement may not exceed the 1st month rental fee divided by 0.15 minus all rental payments.

Social Security Act, Section 1834(a)(7)

For example, HCPCS code K0848, *Grp 3 Power Wheelchair, sling/solid seat/back, patient weight capacity up to and including 300 pounds*, has been designated as a power wheelchair capped rental item. The following are examples of reimbursement scenarios:

- 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, an SA 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.

The examples above do not include examples for beneficiaries who are Medicare and Medicaid dually eligible, nor do they include beneficiaries who may have additional third-party insurance coverage.

7 AAC 120.225, 7 AAC 145.420(h-i)

Pricing for Labor and Repair Parts

Alaska Medicaid reimburses enrolled medical suppliers for labor and repair parts for damaged durable medical equipment (DME), medical supplies, and prefabricated off-the-shelf orthotics at the corresponding labor rate listed on the Alaska Medicaid DMEPOS Interim Fee Schedule for which CMS has issued a price, for each 15 minutes of labor.

7 AAC 145.420(f)

Pricing for Respiratory Therapy Assessments

Alaska Medicaid reimburses medical suppliers for each respiratory therapy assessment provided to a ventilator-dependent recipient based on fees listed on the applicable fee schedule.

7 AAC 145.420

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Pricing for Incontinence and Skin Care Products

Alaska Medicaid reimburses enrolled providers for dispensing specific allowed items described by a national drug code (NDC) listed on the Alaska Medicaid DMEPOS Interim Fee Schedule up to the maximum allowable quantities and amounts defined on the Alaska Medicaid DMEPOS Interim Fee Schedule.

7 AAC 145.420(g)

Pricing for Used and Refurbished DME

Used or refurbished durable medical equipment (DME) will be reimbursed at no more than 75 percent of the set rate for that item.

7 AAC 120.215(j), 7 AAC 120.225(e), 7 AAC 145.420(l)

Pricing for Out-of-State Services

Alaska Medicaid reimburses medical suppliers for items and services provided to recipients physically located outside the state of Alaska at 100 percent of the current quarter's Medicare DMEPOS Fee Schedule for items and services in the state where the item or service is provided.

7 AAC 145.420(b)(2)

Home Infusion Therapy Pricing

Pricing for Services and Supplies with Established Rates

Alaska Medicaid reimburses home infusion therapy providers at a per diem rate listed on the Alaska Medicaid Home Infusion Therapy Fee Schedule, determined as follows:

- 100 percent for the first administered therapy
- 80 percent for the second concurrently administered therapy
- 75 percent for the third and each subsequent concurrently administered therapy

Note: The number of per diem payments made for a therapy period may not exceed the number of days authorized on the order or plan of care.

7 AAC 145.425(b)

Pricing for Services and Supplies without Established Rates

Home infusion therapy services that do not have an established rate on the Alaska Medicaid Home Infusion Therapy Fee Schedule are manually priced by Alaska Medicaid based on 80 percent of the billed charges from in-state enrolled providers for the first nine billings. Thereafter, the payment rate will be based on the 50th percentile of the first 10 billings. Alaska Medicaid will add new payment rates once 10 claims for a home infusion therapy service not already on the schedule are submitted.

A reasonable per diem amount may also be determined by adding up the costs of providing the following services then subtracting the cost of drugs and skilled nursing services:

- Professional pharmacy services, including drug compounding,
- Care coordination,
- Clinical monitoring of the recipient,

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- Purchase or lease of infusion-related equipment and supplies, and
- Delivery and pickup of infusion-related equipment, supplies, and medications.

Alaska Medicaid may then add an amount to provide a fair return to the home infusion therapy provider to ensure that home infusion therapy services continue to be available to that recipient.

7 AAC 145.425(b)(3), (d)

Pricing for Home Infusion Therapy Drugs

Alaska Medicaid reimburses home infusion therapy providers for covered home infusion drugs at the rate determined under 7 AAC 145.400.

7 AAC 145.425(e)

Pricing for Skilled Nursing Services

When the only home infusion therapy service being provided is skilled nursing, Alaska Medicaid reimburses the home infusion therapy provider at a rate not to exceed 85 percent of the RBRVS per visit rate for skilled nursing services.

7 AAC 145.425(a)

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Appendices

Appendix A: Service Authorization Policy Guidance

POLICY

As indicated in Alaska Administrative Code 7 AAC 105.130, the department will not pay for durable medical equipment (DME) or supplies unless the department has approved a service authorization (SA) request. The department may pay for a service without an approved SA if the authorization was not possible before the service was provided or a claim for payment is being processed after the service was provided following determination of a recipient's retroactive eligibility.

SAs must be obtained prior to dispensing of durable medical equipment or prosthetics and orthotics (DMEPOS) except as provided under the temporary COVID guidelines or as provided by the Certificate of Medical Necessity (CMN) – Enteral Nutrition. Retroactive SA requests are reviewed on a case-by-case basis and may be approved when all requirements are met. The temporary COVID guidelines and CMN – Enteral Nutrition form are available on the DMEPOS Provider Information webpage.

PROCEDURE

To request an SA for DMEPOS services:

1. Obtain a dispense/prescription order from the treating physician, physician assistant, or advanced practice registered nurse.
2. Submit all appropriate medical necessity documentation along with a completed CMN, CMN – Incontinence or CMN – Enteral, as applicable to the Conduent SA unit. A valid prescription must also be included if the CMN does not include all the components of the prescription order.
3. For DMEPOS, submit documentation that the requested item or service is necessary to treat, correct, or ameliorate a defect, condition, or physical or mental illness.
4. For miscellaneous items or optimally configured DMEPOS, include the manufacturer information, the item description or number, the global trade item number (GTIN), the suggested list price, and the serial number, as applicable.

Note: DME suppliers may not prepare and are not authorized to document the clinical information and clinical assessment of need portion of a CMN that contains a prescription order. For more information, refer to Prescription Order.

DISPENSING TIMEFRAMES

12-Month Approvals: Items dispensed monthly, such as incontinence and enteral products, may receive an SA for up to a 12-month timeframe. These requests include an initial dispense followed by up to 11 refills as noted on the CMN and prescription order. Other types of items that may be approved for a full year include, but are not limited to, continuous glucose monitor (CGM), ostomy, and respiratory therapy supplies.

Providers requesting an SA for 12 months of dispensed items must submit a completed CMN with all supporting documentation attached asking for a date span of 365 days. Except as provided under temporary COVID guidelines and the CMN – Enteral form, approval will start on the date of review.

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6-Month Approvals: Specialized or custom items such as rehabilitative wheelchairs or complex shower chairs may be authorized for up to a six-month duration to allow time for the order and configuration of complex equipment that may not be readily available in-state.

Providers requesting an SA for items dispensed only once, must submit a completed CMN with all supporting documentation attached. Depending on the type of items requested, the SA may be approved for a timeframe of up to six months with the date of review being the approval start date. Providers must dispense the item within that timeframe to qualify for payment.

3-Month Approvals: Off-the-shelf items classified as DME such as basic shower chairs, positioning cushions, etc. which are dispensed once and are immediately required by the recipient may be authorized for up to a three-month duration to allow for the acquisition of items not currently stocked by the provider. Providers are expected to dispense the approved item as soon as possible.

Capped Rental Timeframes: Items that qualify as capped rentals such as patient lifts, hospital beds, etc. may be authorized for up to a 13-month duration. Upon approval of an SA request for a capped rental item, the Conduent SA unit will issue two separate SAs: the first SA will have an approved timeframe of 3 months and the second SA will have an approved timeframe of the remaining 10 months with the KJ modifier added to the HCPCS code.

Capped rental Items that require document compliance such as CPAPs may be approved for an initial 3-month timespan. To receive an SA for the additional 10 months remaining in the capped rental period, providers must submit an additional request that includes all necessary compliance information. Upon approval of the second SA request, the Conduent SA unit will issue the second SA with an approved timeframe of the remaining 10 months with the KJ modifier added to the HCPCS code.

Items that qualify as capped rentals are indicated as such on the Alaska Medicaid DMEPOS Interim Fee Schedule.

Timeframe Amendments: If a provider cannot dispense an item(s) within the original SA timeframe, the provider may request an SA timeframe amendment. Submitted documentation must include detailed information regarding the reason for the delay in dispensing, including documentation showing the date the item was ordered from the manufacturer or other supplier.

Requesting SA Amendments

DMEPOS providers may request an amendment to an already approved SA in the following situations:

- The SA needs to be ended prior to current expiration date.
- The most recent prescription order calls for an increase in supplies to be dispensed.
- The AK Medicaid Provider ID changes

To request an amendment to end a current SA:

1. Submit a written request documenting the last date of service and total units used from the original SA to the Conduent SA unit.

To request an increase in supplies, a change in HCPCS code, and/or a change in modifier:

1. Submit the new prescription, as applicable, with an updated CMN signed and dated by the prescriber.
2. When only adding or removing a modifier, submit a written amendment request.

   The Conduent SA unit will amend the units, HCPCS code, and/or modifier from the date of review forward. Retroactive increases are not possible and will not be permitted without the expressed written approval from SOA staff.

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To request a change in provider ID where the overall provider will remain the same:

1. Submit a written request documenting the last date of service and total units used from the original SA to the Conduent SA unit.
2. Submit a new, completed SA request under the new provider ID starting 22 days from the last date of service of the previous SA.

   A change in provider ID where the overall provider will remain the same must be submitted timely and will be approved for a valid start date on the new SA no more than 30 days prior to submission to the Conduent SA unit for review.

   The Conduent SA unit will end the original SA with total units used and transfer unused units to a new SA starting 22 days from the last date of service, if submitted timely. In no scenario will the valid start date of the new SA be more than 30 days prior to the date the request is reviewed. The expiration date of the new SA will correspond to the expiration date of the original SA. If a new prescription is provided allowing for a longer expiration date, the expiration date will correspond to the end date of the prescription.

To request a change in provider ID where the overall provider will not remain the same:

1. Submit a new, completed SA request under the new provider ID starting 22 days from the last date of service of the previous SA.
2. Include a recipient signed change of provider form.

   The Conduent SA unit will contact the existing provider to identify the last date of service along with number of units used. The Conduent SA unit will end the original SA with total units used and transfer unused units to the new SA starting 22 days from the last date of service, if submitted timely. In no scenario will the valid start date of the new SA be more than 30 days prior to the date the request is reviewed. The expiration of the new SA will correspond with the end date of the current prescription. If a new prescription is provided allowing for a longer expiration date, the expiration date will correspond to the end date of the new prescription.

For SA requirements for each covered HCPCS code, refer to the Alaska Medicaid DMEPOS Interim Fee Schedule.

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Appendix B: Shipping Reimbursement Policy Guidance

POLICY:

In accordance with 7 AAC 120.200, Alaska Medicaid will consider reimbursement of claims submitted by durable medical equipment (DME) providers and prosthetics and orthotics providers for delivery or shipping costs. Shipping claims submitted under A9999 CG have three distinct criteria for reimbursement. The information below is provided for guidance to ensure shipping claims are processed in the most cost-effective way. Shipping regulations are found in 7 AAC 145.420(k) and 7 AAC 145.421(i) and should any question arise regarding the information below, the regulations ultimately prevail. Additionally, this guidance does not supersede any regulation regarding what types of shipping scenarios, such as items shipped from a manufacturer, may be submitted to request reimbursement.

Shipping claims are permitted when there is a distance of 50 miles or more from the supplier to the recipient and there is no closer supplier to the recipient from which to obtain the items. Suppliers are required to use the most cost-effective shipping method.

Shipping claims less than $50 total

1. For submitted claims where the claim total is less than $50, an itemized list of shipped items must be attached to the claim, but no documentation of shipping receipts needs to be submitted.
2. Shipping claims should be submitted for a total of all shipping costs for one date of service on one claim line and should be less than $50 in total.
3. Shipping documentation, including detailed shipping receipts should be maintained by the provider in their files and submitted if requested by the Department.

Shipping claims for a total of $50 or more with all individual shipped boxes, envelopes, or other shipping vessels less than $50 individually

1. For submitted claims where the claim total is $50 or more, an itemized list of shipped items and delivery confirmation must be included as a claim attachment.
2. Additionally, with the claim, providers must **EITHER**:
    a. Attach an individual receipt for each individual shipped box, envelope, or other shipping vessel showing all detailed information such as the size of the package and its individual shipping charge showing no individual shipping charge is $50 or more, **OR**
    b. Attach a shipping manifest of the shipped packages showing their individual shipping charges and other detailed information, **OR**
    c. In line 19 of the CMS 1500 claim form, enter information as to the number of shipped packages and include that no individual shipped package was $50 or more. For example, “4 boxes shipped, none over $50.”
3. Shipping documentation, including detailed shipping receipts should be maintained by the provider in their files and submitted if requested by the Department.

Shipping claims for a total of $50 or more where any ONE or more of the individually shipped boxes, envelopes, or other shipping vessels is $50 or more or the claim is more than $50 for one individual package

1. For submitted claims where the claim total is $50 or more, an itemized list of shipped items and delivery confirmation must be included as a claim attachment.
2. Additionally, attached to the claim, individual detailed shipping receipts for each package, envelope or other shipping vessel or comprehensive manifest showing the same detailed information must be included with the claim.

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Reminders:

- When submitted information indicates multiple packages were shipped and any one package was $50 or more, each package shipping receipt must include all required details independently.
- The shipping method used must be the most cost-effective method available.

References:

7 AAC 120.200. Enrollment; general provisions; covered items and services
7 AAC 145.420. Durable medical equipment, supplies, prosthetics, orthotics, and respiratory therapy payment rates
7 AAC 145.421. Prosthetics and orthotics payment rates

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Appendix C: Incontinence Policy Clarification

POLICY:

In accordance with 7 AAC 120.200(b), a durable medical equipment (DME) provider may request payment for disposable incontinence products, including diapers, liners, underpads, reusable protective underpads, wipes, and washcloths for recipients three years of age or older.

CLARIFICATION #1:

The Alaska Medicaid DMEPOS Interim Fee Schedule identifies specific quantities of up to 180 allowed per month for HCPCS codes T4521 – T4535 and T4543 – T4544 without an approved service authorization (SA). While each product has its own specific quantity allotment per month, if multiple product sizes/various HCPCS are dispensed at the same time/same month, the total quantity for all combined products remains the same at 180 without an approved SA. Quantities higher than 180 per month for any single product or combination of listed products requires an approved SA.

CLARIFICATION #2:

When dispensing a combination of listed products, secondary claim lines for different size products will deny for NCCI/MUE. These claims cannot be overridden at the claim level and providers must timely utilize the appeals processes to request any denied reimbursement.

Providers have a certain level of discretion when identifying the correct size product needed by each individual. However, there are combinations of products that are not appropriate and should not be dispensed in combination without an SA. The table on the following page identifies which combinations of products are appropriate to dispense, and later, for which a first-level appeal may be approved. First-level appeals for products not listed as appropriate to be dispensed together and without an approved SA, will be denied. Providers requesting second-level appeals must ensure sufficient documentation is submitted to support having dispensed wider product sizes.

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		T4521	T4522	T4523	T4524	T4525	T4526	T4527	T4528	T4529	T4530	T4531	T4532	T4533	T4534	T4543	T4544
		ADULT SIZE BRIEF/DIAPER SM	ADULT SIZE BRIEF/DIAPER MED	ADULT SIZE BRIEF/DIAPER LG	ADULT SIZE BRIEF/DIAPER XL	ADULT SIZE PULL-ON SM	ADULT SIZE PULL-ON MED	ADULT SIZE PULL-ON LG	ADULT SIZE PULL-ON XL	PED SIZE BRIEF/DIAPER SM/MED	PED SIZE BRIEF/DIAPER LG	PED SIZE PULL-ON SM/MED	PED SIZE PULL-ON LG	YOUTH SIZE BRIEF/DIAPER	YOUTH SIZE PULL-ON	DISP BARIATRIC BRIEF/DIAPER	ADULT PROT UNDERWEAR/PULL-ON, ABOVE XL
T4521	ADULT SIZE BRIEF/DIAPER SM																
T4522	ADULT SIZE BRIEF/DIAPER MED																
T4523	ADULT SIZE BRIEF/DIAPER LG																
T4524	ADULT SIZE BRIEF/DIAPER XL																
T4525	ADULT SIZE PULL-ON SM																
T4526	ADULT SIZE PULL-ON MED																
T4527	ADULT SIZE PULL-ON LG																
T4528	ADULT SIZE PULL-ON XL																
T4529	PED SIZE BRIEF/DIAPER SM/MED																
T4530	PED SIZE BRIEF/DIAPER LG																
T4531	PED SIZE PULL-ON SM/MED																
T4532	PED SIZE PULL-ON LG																
T4533	YOUTH SIZE BRIEF/DIAPER																
T4534	YOUTH SIZE PULL-ON																
T4543	DISP BARIATRIC BRIEF/DIAPER																
T4544	ADULT PROT UNDERWEAR/PULL-ON, ABOVE XL																

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