



Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID PROVIDER MANUAL UPDATE

TO: All *Durable Medical Equipment and Supplies* providers participating in the Virginia Medical Assistance Program, Managed Care Organizations, and holders of the Durable Medical Equipment and Supplies Provider Manual

MEMO: Update

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

DATE: May 20, 2009

SUBJECT: Update to Second Edition of the Durable Medical Equipment and Supplies Provider Manual

The purpose of this memorandum is to highlight changes the Department of Medical Assistance Services (DMAS) made to several sections of Appendix B in the "Durable Medical Equipment and Supplies Listing" of the Durable Medical Equipment and Supplies Manual. This memo will highlight changes and additions to the Appendix B, as well as providing education related to nutritional supplements. Please see the bottom of each section for comments on changes to that section.

If providers are unsure of the appropriate code to use for a particular item, one resource is the Noridian site, which is designed to help providers with DME coding. Providers can search by different criteria and also by brand name. The website can be accessed at <https://www.dmepdac.com/dmecsapp/do/search>.

Please note: Appendix B of the Durable Medical Equipment (DME) and Supplies Provider Manual has been updated and is now available on the DMAS website (www.dmas.virginia.gov), or you may contact Commonwealth-Martin to receive a copy of the updated Appendix B.

Durable Medical Equipment and Supplies Program Update: Appendix B

Nutritional Supplements – June 2009

Starting June 1, 2009, First Health Services will process all nutritional supplement claims that have a fee of UCC per can. Nutritional supplements that have a set fee will remain the same paying per unit which is 100 calories. Providers should refer to the Appendix B to see which codes have a fee of UCC. "UCC" means the provider's usual and customary charge to the general public and is not exceed MSRP/retail. For these nutritional supplement codes, preauthorization is not required to determine a payment amount. Instead, the provider must submit an invoice with the claim documenting the usual and customary charge to the general public. Documentation should be in the form of an invoice or purchase order that shows MSRP or retail. Claims will be paid based on the invoice and it should be evident to the claims representative which item on the invoice corresponds to the item billed. Claims will not be paid above the retail amount and a mark up is never given for UCC items. If a provider charges the general public an amount less than retail this should be noted on the invoice or on an invoice created by the provider and be evident in the billed amount.

Providers should bill for the date of delivery if possible. Providers who deliver all products that will be used for the month on one date should bill the entire amount for that month on one date; this will indicate to the claims representative that this is a monthly delivery. If the provider makes multiple shipments per month the provider

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should provide a date span. **Note:** If providers that typically deliver all products in one shipment per month need to deliver additional product in the same month the provider will then need to adjust the original paid claim.

Example 1: Provider X delivers 2 cases of nutritional supplements (24 cans per case) each month to a recipient. Each case retails at \$51 dollars. This month the delivery occurs on the 3rd of March. The provider will use a billing date of March 3, 2009 and bill 48 cans at \$2.13 per can for a total of \$102.24.

Example 2: Provider X delivers 1 case (24 cans per case) every two weeks. Each case retails for \$51 dollars. The first delivery is made on March 2nd and the second delivery is made on March 16th. For the first delivery the provider will use a date span of March 2nd through March 15th. For the second delivery the provider will use a date span of March 16th through March 29th. The provider will bill for 24 cans at \$2.13 per can for a total of \$51.12 for each two week date span.

Note: Often times, providers will need to deliver a certain number of cans that may mean breaking a case. The same principal will apply in these situations. If the recipient needs 110 cans per month and a case has 24 cans the recipient will receive 4 cases and 14 loose cans. The provider should determine the can price by dividing the case price by the number of cans per case. For example: if the case is \$51.00 and there are 24 cans the price per can is \$2.13. The provider would then bill for the 110 cans at \$2.13 per can which would be a total of \$234.30.

We have recently seen a problem with the provider's invoice not clearly showing UCC/MSRP/Retail. The claims representative will pay based on the invoice submitted. If the invoice only shows the provider's cost that is all that will be reimbursed to the provider regardless of the amount requested. The purpose of the invoice is to justify the total billed amount since DMAS will not pay over the retail amount. **Note:** The provider must make sure the number of cans per case is indicated on the invoice for pricing as well as the number of cans billed for the recipient during the dates billed.

The following codes have had a change to the Billing Unit in the Appendix B effective 6/1/09.

HCPCS code	Description	Billing unit	Fee
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and mineral, may include fiber.	Per can	UCC
B4158	Enteral formula, for pediatrics, nutritional complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron.	Per can	UCC
B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats carbohydrates, vitamins and minerals, may include fiber and/or iron	Per can	UCC
B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber	Per can	UCC
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, include fats, carbohydrates, vitamins and minerals, may include fiber	Per can	UCC
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber	Per can	UCC

Conversion of calories to units

The following information may be used to assist in determining the units to bill for nutritional supplements that have a set fee and have a billing unit of 100 calories = 1 unit. To convert a product from cans or container the following formula may be used:

Example: 30 cans of Brand X, non-routine formula, are provided per month, each can contains 640 calories. To convert the units to bill:

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1. Take the number of cans times the number of calories per can and the total will equal the number of calories in the total number of cans.
 - 30 cans x 640 calories per can = 19200 calories total in the 30 cans.
2. Then take the total number of calories and divide that number by 100 to equal the number of billing units.
 - 19200 total calories in 30 cans divided by 100 = 192 units.
3. 192 units would then be billed on the claim.

Pricing Error Change

Appendix B section: Apnea, Respiratory, Oxygen and Vents

The code below had an error in the fee column of the Appendix B. The fee listed below is the correct reimbursement price and claims have been reimbursed on the price since 2/1/09.

HCPCS code	Description	Billing unit	Correct Fee
A7037	Tubing used with positive airway pressure device	Each	\$36.99

Service Limit Change

Appendix B section: Beds, Mattresses and Accessories

The codes below will have a service limit change. This change will occur so that the service limit matches the criteria in the Therapy bed section of the DME and Supplies Manual. This code has always required PA but the PA will be limited to a two month period per authorization as stated in the DME policy manual. This change will become effective 6/1/09.

HCPCS code	Description	Billing unit	Service limit
E0193 RR	Powered Air Flotation Bed (low air loss therapy)	Day	2 months
E0194 RR	Air Fluidized Bed	Day	2 months

Code Changes and Additions

Appendix B section: Apnea, Respiratory, Oxygen, and Vents

The code A4625 has been unspecific to patient type in the Appendix B. This code will now change to reflect the current definition and code A4629 will be added effective 4-15-09. See the descriptions below. Additions effective 6/1/09.

HCPCS code	Description	Billing unit	Service limit
A4625	Tracheostomy care kit for a new tracheostomy	Each	\$7.28
A4629	Tracheostomy care kit for an established tracheostomy	Each	\$4.86

Appendix B section: Diabetic Products

The following code is being added effective 4-15-09 to this section of the Appendix B.

HCPCS code	Description	Billing Unit	PA type	Fee	Limit
A4258	Spring-Powered device for lancet	Each	N	\$16.34	1/Month

COMMUNICATION TO DME PROVIDERS

DMAS has designed an email address specifically for providers to email questions about DME to DMAS (dme@dmavirginia.gov). These questions should pertain to policies, codes, or rates and should not pertain to preauthorizations, as these questions should continue to be directed to the preauthorization contractor, KePRO. See Appendix D of the Medicaid Durable Medical Equipment and Supplies Manual for more information regarding preauthorization.

To subscribe to this email address, send an email to dme@dmavirginia.gov. On the subject line of the e-mail form, type, "subscribe" (without the quotes). This is an automated system. If you put anything else on the subject line, you will not be added to the list. Please include "recipient", "provider", or "other", which ever best describes you, in the body of your e-mail. To unsubscribe, send an email to DMAS dme@dmavirginia.gov. On the subject line of the email form, type, "unsubscribe" (without the quotes).

REQUESTS FOR DUPLICATE REMITTANCE ADVICES

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices will no longer be printed and mailed free of charge. Duplicate remittance advices will be processed and sent via secure email. A processing fee for generating duplicate paper remittance advices will be applied to paper requests, effective July 1, 2009.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. For more information on the services that are offered contact the vendors.

Passport Health Communications, Inc.
www.passporthealth.com
sales@passporthealth.com
Telephone #: (888) 661-5657

SIEMENS Medical Solutions – Health Services
Foundation Enterprise Systems/HDX
www.hdx.com
Telephone #: (610) 219-2322

Emdeon
www.emdeon.com
Telephone #: (877) 363-3666

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Providers must check the recipient's eligibility via the web-based system or MediCall to verify enrollment in Plan First. The system will have a prompt stating the enrollee has "family planning coverage only". There is not an identifier on the Medicaid card to alert the provider of Plan First enrollment.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays, to answer questions. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid provider identification number available when you call.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-eneewsletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

Attached Number of Pages: (2)

DURABLE MEDICAL EQUIPMENT AND SUPPLIES MANUAL
REVISION CHART
May 20, 2009

SUMMARY OF REVISIONS

MANUAL SECTION	MATERIAL REVISED	NEW PAGE NUMBER(S)	REVISED PAGE(S)	REVISION DATE
Appendix B	Apnea, Respiratory, Oxygen and Vents	Entire Section	Entire Section	5/20/2009
Appendix B	Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes Section	Entire Section	Entire Section	5/20/2009
Appendix B	Bed, Mattresses and Accessories	Entire Section	Entire Section	5/20/2009
Appendix B	Diabetic Products	Entire Section	Entire Section	5/20/2009

FILING INSTRUCTIONS

MANUAL SECTION	DISCARD	INSERT	OTHER INSTRUCTIONS
Appendix B	Apnea, Respiratory, Oxygen and Vents	Entire New Section	
Appendix B	Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes Section	Entire New Section	
Appendix B	Bed, Mattresses and Accessories	Entire New Section	
Appendix B	Diabetic Products	Entire New Section	

Examples for Nutritional Supplement Claims

Example 1: Provider X delivers 2 cases of nutritional supplements (24 cans per case) each month to a recipient. Each case retails at \$51 dollars. This month the delivery occurs on the 3rd of the March. The provider should use a billing date of March 3, 2009 and bill 48 cans at \$2.13 per can for a total of 102.24.

Example 2: Provider X delivers 1 case (24 cans per case) every two weeks. Each case retails at \$51 dollars. The first delivery is made on March 2nd and the second delivery is made on March 16th. For the first delivery the provider will use a date span of March 2nd through March 15th. For the second delivery the provider will use a date span of March 16th through March 29th. The provider should bill for 24 cans at \$2.13 per can for a total of \$51.12 for each two week date span.

Note: Often a provider will need to deliver a certain amount of cans that may mean breaking a case. The same principal will apply in these situations. If the recipient needs 110 cans per month and a case has 24 cans, the recipient will receive 4 cases and 14 loose cans. The provider should determine the can price by dividing the case price by the number of cans per case. For example: if the case is \$51.00 and there are 24 cans the price per can is \$2.13. The provider should then bill for the 110 cans at \$2.13 per can which would total \$234.30.

The provider should submit an invoice that clearly shows the UCC/MSRP/Retail. The claims representative should pay based on the invoice using the examples listed above. The purpose of the invoice is to justify the total billed amount since DMAS will not pay above retail. Claims should be paid based on the invoice and it should be evident to the claims representative which item on the invoice corresponds to the item billed. If the invoice does not clearly show which item is being billed or if the invoice does not clearly show the retail price the claim should not move forward. It is the provider's responsibility to provide the claims representative with this information.

If the provider charges the general public less than retail this should be noted on the invoice or an invoice created by the provider and should be evident in the billed amount.

Providers that deliver all products on one date should bill for the delivery date on the claim letting the claim representative know this is a delivery for the entire month. Providers that deliver product on multiple dates will bill for a date span. Note: If providers that typically deliver all products in one shipment per month need to deliver additional product that month the provider then need to adjust the original paid claim.