DMEPOS PROPOSED REGULATIONS: QUESTIONS		RESPONSES
1.	What is the timeline for these regulations to be implemented? When will the new fee schedule take effect? When will these changes be reviewed?	Regulatory packages go through a defined process. Information on the regulatory process may be found at: http://www.law.alaska.gov/doclibrary/drafting_manual.html Once the public comment period closes, it could be estimated that the final effective date might be somewhere between 3 to 6 months from closing. This date range is dependent upon a number of factors. Written comments received during the public comment period are carefully considered, including comments on costs of compliance to private persons. Substantive changes may require an additional public comment period to ensure the public has an opportunity to review the changes. While this may extend the length of time to adoption, it is an important step in the process. The fee schedule is part of the regulatory package and will be adopted by reference when the final version of the proposed regulations is filed by the Lieutenant Governor.
2.	All base prostheses billing codes would require prior authorization. What is the thought behind this change? These codes are required for use with new amputees.	The intent of the regulatory change was not to expand P&O service authorization requirements, only to maintain the service authorization requirement for Durable Medical Equipment (DME) over $1,000 per item. Consideration will be given to exclude specific prostheses billing codes from service authorization in the final revision of the fee schedule; the proposed fee schedule will be updated to reflect such changes.
3.	L2820 and L2830 extend the life of an orthosis and avoid making a new one when all that is required is a new interface to protect the patient's skin. This does not exceed the price of a new orthosis but is a common need in our active and remote population. Why are these codes excluded?	Medicare rules were consulted in the decision to propose exclusion of these replacement components. Based on comments received, consideration will be given to allow coverage in the event the component becomes worn. The proposed fee schedule would be updated accordingly to reflect the change.

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4.	Who will be communicating these decreased quantity limits to the recipients? Are they to purchase their additional quantity or will there be a DHSS process in place to submit a PA for additional quantity? What additional information would be required for what is now considered over-utilization?	Program changes are communicated to recipients through multiple means including public notice of regulations, communications to enrolled providers through remittance advice messages, provider billing manuals, other publications, and posting of program rules on the program's site. The Department will utilize a communication plan to disseminate the information once final regulations are adopted. The Department has maintained an avenue for situations where clinical needs support medical necessity of utilization beyond the proposed limits. Under 7 AAC 120.210(b), a "service authorization is required for … (2) medical supplies that exceed the maximum units or a 30-day limit set by the Department." For example, T4528 ordered at 150 units per month or less will not require a service authorization, but T4528 ordered at 210 units per month would require a service authorization. Under current regulation, T4528 requires service authorization regardless of the amount ordered. The intent of this change is to decrease administrative burden on the provider. A CMN (Certificate of Medical Necessity) will continue to be required.
5.	Is DHSS going to modify the current incontinence CMN to include the additional requirements?	The Department will work to ensure that any necessary changes that are needed on associated forms are made to comply with adopted regulations. Revised forms will be made available on the Enterprise web portal for ease of access.
6.	If these regulations are adopted, the savings to the state, will be 300K per year. How did you arrive at this number?	The Department estimates the proposed changes will result in an increase of $400,000 to the Medicaid DMEPOS budget. This increase is primarily attributed to an increase in the reimbursement rates for Prosthetic and Orthotic codes of approximately 20% above current reimbursement rates. DME and Medical Supply code reimbursement may see an increase of up to 10% on some codes but smaller increases on other codes. The estimated increase to the budget was based on an evaluation of historical billing patterns against the proposed reimbursement rates.
7.	Was there any consideration given to the limited access that may not be available for certain lines of DME such as hospital beds, sleep equipment, wheelchairs and custom mobility if these regulations are implemented? Where will the custom mobility recipients obtain service if we are unable to support these regulations?	The Department attempts to balance patient access with fiduciary responsibility when proposing regulatory changes and is open to comments and suggestions on areas where access may be impacted in the proposed regulations. Providers are encouraged to provide specific comments during the public comment period to further inform regulation development.

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8.	Why are chairs that are upfront purchase with Medicare not the same with Medicaid? What happens with rentals for patients who lose their Medicaid coverage during the rental period?	The Department will give consideration to alignment with Medicare's Purchase Option of Capped Rental Items guidance, including Complex Rehabilitative Power Wheelchairs and Standard Power Wheelchairs. Providers are encouraged to provide specific comments with regards to the proposed capped rental regulations during the public comment process to further inform regulation development.
9.	What methodologies were used to arrive at the new volume levels?	The Department used multiple tools to arrive at the new volume levels, including NCCI MUE (National Correct Coding Initiative Medically Unlikely Edits) rules, review of other state quantity limits, historical claims review, and scoping meetings where information and suggestions were offered by providers.
10.	Why has there been a requirement added that only new equipment can be rented out to Medicaid recipients? This is not in line with Medicare's requirement of new or like new equipment, which can be provided as long as it has an RUL of 5 years.	The proposed changes to the regulations adds the clarifier to the existing regulation that the provider need not replace the item with a new item if a used or refurbished item was used in compliance with 7 AAC 120.299. The proposed regulations state in 7 AAC 120.215(c): "(2) replaces the item with a new item if it was previously used by a person other than the recipient before it was rented to the recipient **, unless the item is used or refurbished equipment, as defined in 7 AAC 120.299, and is billed to the department as such in compliance with this section**. "
11.	How did you arrive at the cost plus percentages that are in these regulations for codes not priced?	The Department worked with the Office of Rate Review to align reimbursement with national pricing while providing a sustainable reimbursement structure. Providers are encouraged to consult the Medicare Pricing, Data Analysis and Coding site (PDAC) and the corresponding DMEPOS Product Classification List to ensure the appropriate HCPCS code is being used when billing for a specific product.
12.	What is the plan for pediatric patients under 3 that are needing specialized formulas? What about the current recipients receiving them? Can patients over the age of 18 receive pediatric formulas if medically necessary?	The Department did not intend for an age restriction for medically necessary specialized "formulas" and it is not included in regulation text. The proposed fee schedule will be updated to clarify. The service authorization process will be available to evaluate situations where medical necessity is demonstrated by the prescriber.
13.	For incontinence products, specific products have an age limitation which seems arbitrary since fit is more closely aligned with weight. What about the exceptions to the age limitation for these products?	Under the proposed regulations, the Department is not requiring service authorization for incontinence products that conform to the criteria posted in regulation and the corresponding fee schedule. For exceptions to the criteria for incontinence products, the service authorization process will be available to evaluate situations where medical necessity is demonstrated by the prescriber.

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14.	Was the state aware that eliminating higher allowables for T and B codes, would eliminate providers' ability to supply them? Are you eliminating cost plus 40% for these products?	In reviewing historical claims submittals for B and T codes, it was observed that a significant amount of time was required by providers to submit additional paperwork to justify higher allowable requests within this category. Therefore, the Department is proposing a reimbursement rate structure that takes into account the higher acquisition costs of products within these categories that would allow claims to process and pay at the time the claim is submitted. The result minimizes manual intervention, thus increasing claims processing efficiency, decreasing time to reimbursement, and decreasing the administrative burden on the provider. Providers are encouraged to provide comments on specific products of concern, including proposed reimbursement of those products, during the public comment process to further inform regulation development.
15.	Are providers limited to supply only the brand name products listed in the enteral fee schedule?	Enteral products are not restricted to the listed products. Enteral products supplied must be billed with the appropriate HCPCS code. A provider may bill B4161 with the "CG" modifier if the product dispensed is listed on that line of the fee schedule. For example, Elecare® may be billed as B4161 CG. The Product code/NDC is required on all enteral claims which allows the system to calculate the appropriate pricing at the time of claim submittal.
16.	HCPCS code B4104 shows "EF additive, fiber" will not be covered. What does this mean? Will Medicaid coverage for the Promote with Fiber product be stopped? If so, what is the rationale for the change?	The products under HCPCS code B4104, which are items that might be added to a complete enteral formula (e.g., extra fiber), would not be covered under the proposed regulations. The Department will continue to cover commercially available products that include fiber in their formulations, such as Promote with Fiber which is billed under B4150.
17.	With the proposed movement to A6250 and A4335 by NDC unit, is pricing set by NADAC? What is the pricing proposed for these items? Is it now billing by the ounce or bottle? How do I determine the reimbursement for A6250 products?	The per-NDC units rate for items covered under A6250 is based on WAC unit pricing effective on the date of the fee schedule. For creams, ointments, pastes, and powders, the NDC unit is grams; for solutions, sprays, gels, cleansers, and lotions, the NDC unit is milliliters (mL). Providers must submit both the HCPCS units dispensed and the correct NDC units on the claim. Correctly submitted claims will not require manual pricing, thus making the claims processing for these items more timely and efficient. Items covered under A4335 require manual pricing.

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18.	There are codes that are currently being used that right now have no price listed. What does that mean (e.g., A4466, A4435)?	In the transition to the new fee schedule structure, the Department utilized "$0.00" in the reimbursement field to represent what is currently understood as "By Report". Further information on how reimbursement will be determined may be found in the proposed regulations under 7 AAC 145.420(c).
19.	There are no maximum units listed for gloves on the fee schedule, is this correct? Can gloves be dispensed to individuals residing in Assisted Living Facilities?	Thank you for bringing this oversight to our attention. The Department will consider appropriate utilization measures on this product. As per guidance distributed on March 10, 2016, the cost of gloves used by employees of an assisted living home in the provision of care for a Medicaid-eligible resident are the responsibility of the employer and are not separately reimbursable to the durable medical equipment (DME)/medical supplies provider by the Alaska Medicaid program. http://manuals.medicaidalaska.com/docs/dnld/Update_Policy_Clarification_Gloves.pdf
20.	Can a patient pay cash if they want to replace or repair an item more frequently than what is allowed by Medicaid?	The Department does not currently have specific regulations restricting a patient from paying cash for replacement items; however, a provider may not influence a patient to pay cash for items. If the patient is a dual eligible recipient, it is expected that the provider would ensure compliance with Medicare rules. Providers are encouraged to refer to 7 AAC 105.400 for additional information.
21.	Why doesn't E0241 say "installed"?	The Department has maintained the formal HCPCS long description for E0241 as "Bath tub wall rail, each" on the fee schedule for consistency. No change to the expectations for this HCPCS has been proposed with the regulations.