DEPARTMENT OF HEALTH & SOCIAL SERVICES

PROPOSED CHANGES TO REGULATIONS

- ***7 AAC 115. Medicaid Coverage; Therapies and Related Services.***
  - *Sec. 110. Occupational therapy services;*
  - *Sec. 310. Physical Therapy Services.*

- ***7 AAC 120. Medicaid Coverage; Prescription Drugs and Medical Supplies; Durable Medical Equipment; Transportation Services.***
  - *Sec 200. Enrollment; general provisions; covered items and services;*
  - *Sec 205. Noncovered services;*
  - *Sec 210. Service authorization;*
  - *Sec 215. Purchase of items;*
  - *Sec 220. Replacement of items;*
  - *Sec 225. Rental of items; general provisions;*
  - *Sec 230. Rental of items; changes during rental periods; &*
  - *Sec 299. Definitions.*

- ***7 AAC 120.300-.399.Prosthetics and Orthotics (NEW)***
  - *Sec 300. Enrollment; general provisions; covered items and services;*
  - *Sec 305. Noncovered services;*
  - *Sec 310. SA authorization;*
  - *Sec 315. Purchase of items;*
  - *Sec 320. Replacement of items;*
  - *Sec 325. Rental of items; general provisions;*
  - *Sec 330. Rental of items; changes during rental periods; &*
  - *Sec 399. Definitions.*

- ***7 AAC 145. Medicaid Payment Rates.***
  - *Sec 420. Durable medical equipment, supplies, and respiratory therapy payment rates;*
  - *Sec 421. Prosthetics and orthotics payment rates (NEW).*

- ***7 AAC 145.421. Prosthetics and Orthotics Payment Rates (NEW)***

- ***7 AAC 160. Medicaid Program; General Provisions.***
  - *Sec 900. Requirements adopted by reference.*

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PUBLIC REVIEW DRAFT
October 16, 2017

COMMENT PERIOD ENDS: December 4, 2017
Please see the public notice for details about how to comment on these proposed changes.

Notes to reader:

1. Except as discussed in note 2, new text that amends an existing regulation is **bolded and underlined**.

2. If the lead-in line above the text of each section of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, paragraph, or subparagraph is being repealed and readopted (replaced), *the new or replaced text is not bolded or underlined*.

3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is to be deleted.

4**.** When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

5. Only the text that is being changed within a section of the current regulations is included in this draft. Refer to the text of that whole section, published in the current Alaska Administrative Code, to determine how a proposed change relates within the context of the whole section and the whole chapter.

Title 7 Health and Social Services.

Chapter 115. Medicaid Coverage; Therapies and Related Services.

Sec 110. Occupational therapy services.

7 AAC 115.110 is amended by adding a new sub-section to read:

(e) Occupational therapy providers enrolled under this section may request payment for select medically necessary durable medical equipment, medical supplies, or prefabricated off-the-shelf orthotics listed on the HCPC Fee Schedule for Occupational Therapy Services table adopted by reference in 7 AAC 160.900 if the item is furnished to a recipient and dispensed by the occupational therapist in the standard course of therapy within the scope of that professional's license.

(Eff. 2/1/2010, Register 193; am ____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 115.310 is amended by adding a new sub-section to read:

(f) Physical therapy providers enrolled under this section may request payment for select medically necessary durable medical equipment, medical supplies, or prefabricated off-the-shelf orthotics listed on the HCPC Fee Schedule for Physical Therapy Services table adopted by reference in 7 AAC 160.900 if the item is furnished to a recipient and dispensed by the physical therapist in the standard course of therapy within the scope of that professional's license.

(Eff. 2/1/2010, Register 193; am ____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

The title for chapter 120 is amended to read:

Chapter 120. Medicaid Coverage; Prescription Drugs and Medical Supplies; Durable Medical Equipment; <u>Prosthetics and Orthotics;</u> Transportation Services.

Sec 200. Enrollment; general provisions; covered items and services.

7 AAC 120.200(a) is repealed and readopted to read:

7 AAC 120.200. Enrollment; general provisions; covered items and services.

(a) To be eligible for payment under 7 AAC 105 – 7 AAC 160 for providing durable medical equipment, medical supplies, and related services, a provider must

(1) hold a valid business license issued under AS 43.70 and 12 AAC 12;

(2) be enrolled in accordance with 7 AAC 105.210 as a durable medical equipment/medical supplies provider, if the provider provides

(i) durable medical equipment;

(ii) medical supplies;

(iii) respiratory therapy assessment visits;

(iv) home infusion therapy services; or

(v) pre-fabricated off-the-shelf orthotics;

(3) provide to the department evidence that the provider is enrolled as a Medicare provider for durable medical equipment and supplies and Medicare enrollment is maintained concurrent with Medicaid enrollment;

(4) comply with federal certification standards found in 42 CFR 424.57(c) throughout enrollment.

7 AAC 120.200(b) is repealed and readopted to read:

(b) Subject to the applicable provisions of 7 AAC 120.200 - 7 AAC 120.299, providers enrolled under this section may request payment for medically necessary durable medical equipment, medical supplies, prefabricated off-the-shelf orthotics, or related covered services furnished to a recipient, if

(1) the item is

(A) prescribed by a physician, physician assistant, or advanced nurse practitioner who is enrolled in accordance with 7 AAC 105.210 and acting within the scope of that person's license;

(B)appropriate for use in the recipient's home or community;

(C)not provided by, or under arrangements made by, a home health agency;

(D) dispensed pursuant to a valid prescription order; or

(E) a repair of a recipient's current durable medical equipment and all of the following are met:

(i) all warranties are expired;

(ii) the cost of the repair is less than fifty percent of the cost of a new durable medical equipment and the provider has submitted supporting documentation; and

(iii) the repair has a warranty for a minimum of ninety days.

(2) the provider furnishes orientation and training to the recipient regarding the proper use of the item, and includes proof of compliance with this paragraph in its records; the provider shall submit this proof to the department upon request;

(3) service authorization, if required under 7 AAC 120.210, is obtained from the department.

7 AAC 120.200(c) is repealed and readopted to read:

(c) Subject to the applicable provisions of 7 AAC 120.200 - 7 AAC 120.299, providers enrolled under this section may request payment for continuous oxygen used by a recipient in a skilled nursing facility or intermediate care facility if the skilled nursing facility or intermediate care facility has not been authorized to provide continuous oxygen under 7 AAC 140.580.

7 AAC 120.200(d) is repealed and readopted to read:

(d) Subject to the applicable provisions of 7 AAC 120.200 - 7 AAC 120.299, providers enrolled under this section may request payment for the purchase or rental of durable medical equipment for a recipient in a skilled nursing facility or intermediate care facility if the purchase or rental 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 given service authorization only if the equipment is not provided by the skilled nursing facility or intermediate care facility. The department may pay for trial use of rental equipment necessary for preparing a recipient for discharge.

7 AAC 120.200(e) is repealed and readopted to read:

(e) Subject to the applicable provisions of 7 AAC 120.200 - 7 AAC 120.299, providers enrolled under this section may request payment for home infusion therapy services if the services are

(1) ordered by a physician, a physician assistant, or an advanced nurse practitioner;

(2) reviewed at least every 60 days by the physician, physician assistant, or advanced nurse practitioner to determine the ongoing medical need for the service; and

(3) appropriate for use in the recipient's home or community.

7 AAC 120.200(f) is repealed and readopted to read:

(f) If a home infusion therapy provider is also providing skilled nursing visits ordered by the physician, physician assistant, or advanced nurse practitioner under (e) of this section, those skilled nursing visits for home infusion therapy must be provided in the recipient's home, except that the department will pay a home infusion therapy provider

(1) for one skilled nursing visit for catheter insertion and patient instruction at

(A) a hospital on the day of discharge from the hospital;

(B) a hospital one day before the day of discharge from the hospital; or

(C) one of the following on the day of surgery:

(i) a hospital-based infusion clinic;

(ii) an ambulatory surgical center;

(2) for no more than one skilled nursing visit per day, if the total cumulative time of the visit, including multiple trips, is two hours or less; if the total cumulative time exceeds two hours in the same day, each additional hour is paid separately;

(3) a per diem amount, if

(A) the skilled nursing visit is provided on the same day the recipient receives infusion therapy services at a hospital-based infusion clinic or an ambulatory surgical center; and

(B) a physician, physician assistant, or advanced nurse practitioner has ordered additional infusion therapy services to continue in the home.

7 AAC 120.200(g) is repealed and readopted to read:

(g) Subject to applicable provisions of 7 AAC 120.200 - 7 AAC 120.299, providers enrolled under this section may request payment for medically necessary medical supplies or respiratory therapy assessment visits furnished to a recipient who is receiving hospice care services, if the supplies or assessment visits are

(1) ordered by a physician as part of a written hospice plan of care under 7 AAC 140.275 and the physician reviews the recipient's continuing medical need for the items; and

(2) appropriate for use in the recipient's home or community.

7 AAC 120.200(h) is repealed and readopted to read:

(h) Subject to the applicable provisions of 7 AAC 120.200 - 7 AAC 120.299, providers enrolled under this section may request payment for dispensing specific covered items described by a national drug code (NDC) listed on the *Alaska Medicaid DMEPOS Fee Schedule* billed under HCPCS code A6250 up to the maximum allowable quantities and amounts defined on
the Alaska Medicaid DMEPOS fee schedules adopted by reference in 7 AAC 160.900 if the item is medically necessary due to a medical condition resulting in bladder or bowel incontinence:

(1) skin sealant;

(2) skin protectant;

(3) skin moisturizer;

(4) skin ointment;

(5) skin cleanser;

(6) skin sanitizer.

7 AAC 120.200(i) is repealed and readopted to read:

(i) Providers enrolled under this section may request payment for the reasonable and necessary direct costs of delivery or shipping durable medical equipment, medical supplies, prefabricated off-the-shelf orthotics, or home infusion therapy pharmaceutical product incurred by the dispensing provider when using the most cost-effective means.

(1) To be eligible for payment, the following conditions must apply

(A) the recipient resides outside the municipality where the business of the enrolled dispensing provider is located, 50 air miles.

(B) the item or service is unavailable from a provider enrolled under this section in the municipality in which the recipient resides, defined as within 50 air miles.

(C) if for shipping home infusion pharmaceutical product, the cost of the shipping via the most cost-effective method exceeds 40% of the sum of the per diem rate for the number of days represented in the shipment.

(2) When the charge submitted by the provider exceeds $50, the claim and supporting documents must include

(A) the recipient’s name;

(B) the address to where the item was delivered;

(C) an itemized list of the products included in the shipment or delivery, to include product name, product identifier, quantity, and serial number, when applicable;

(D) the shipment and delivery date;

(E) the recipient’s signature with date of receipt;

(F) the total charges minus all discounts, substantiated by a paid shipping invoice reflecting the actual payment.

7 AAC 120.200(j) is repealed and readopted to read:

(j) The department will not pay separately for the costs of administrative expenses. The following costs are considered administrative expenses and are included in the payment for the durable medical equipment, medical supplies and pre-fabricated off-the-shelf orthotics:

(1) telephone responses to questions;

(2) mileage;

(3) travel expenses;

(4) travel time;

(5) setting up an item;

(6) installation;

(7) orientation and training regarding the proper use of the item;

(8) preparation and maintenance of necessary records required under 7 AAC 105.230 and 7 AAC 120.210.

7 AAC 120.200(k) is repealed and readopted to read:

(k) A prescribing provider under (b)(1)(A) of this section shall review the continued medical necessity of durable medical equipment or supplies billed to Alaska Medicaid at least annually. The department may require more frequent or less frequent reviews based on the nature of the item prescribed. Providers enrolled under this section engaging in repairs of a DME product attest to the continued medical necessity of the product when submitting a claim requesting payment. The department may seek

recovery under 7 AAC 105.260 of payment for services or items determined to be medically unnecessary and impose sanctions under 7 AAC 105.400 - 7 AAC 105.490.

7 AAC 120.200(*l*) is repealed and readopted to read:

A provider of durable medical equipment, medical supplies, and prefabricated off-the-shelf orthotics shall

(1) document and maintain record of a recipient's request for a refill, including the quantity of items that:

(A) the recipient needs and requests; and

(B) still remain;

(2) supply no more than the difference between what the recipient needs and what still remains, except an allowance of a 5 day on-hand emergency overlap supply may be permitted;

(3) accept returns from recipients of any substandard item; for purposes of this paragraph, "substandard item" means an item that does not function in a manner that meets the prescribed need or specifications;

(4) upon request, provide proof, in the form of copies of letters, logs, or signed notices, that it has provided Medicaid recipients with warranty information for Medicaid-covered items;

(5) maintain proof of receipt for items supplied to recipients consistent with 7 AAC 105.230; the provider shall submit the proof of receipt to the department upon request; and

(6) ensure patient is eligible to receive the product.

7 AAC 120.200(m) is repealed and readopted to read:

(m) The department will only pay for medically necessary medical supplies for up to a 30-day supply within each 25 day period. The department may seek recovery under 7 AAC 105.260 of payment

for services or items determined to be medically unnecessary and impose sanctions under 7 AAC 105.400 - 7 AAC 105.490.

7 AAC 120.200(n) is repealed and readopted to read:

(n) The department may enter into a contract under AS 36.30, a grant, or other arrangement permitted by law, with a provider authorizing that provider to

(1) provide durable medical equipment, medical supplies or pre-fabricated off-the-shelf orthotics; or

(2) serve a specific geographic region and provide incontinence supplies, including

(A) garments;

(B) liners;

(C) underpads;

(D) nonsterile gloves;

(E) diaper wipes; and

(F) disposable washcloths.

7 AAC 120.200(o) is repealed:

(o) Repealed ____/____/____. (Eff. 2/1/2010, Register 193; am 7/7/2010, Register 195; am ____/____/____, Register ____)

7 AAC 120.200(p) is repealed and readopted to read:

(p) Providers enrolled under this section may request payment and the department may pay for disposable incontinence products including diapers, liners, underpads, reusable protective underpads, wipes, and washcloths for recipients three years of age or older if:

(1) the items meet national quality standards as defined by the National Association for Continence (NAFC);

(2) the items are prescribed on an incontinence certificate of medical necessity prescription, certified annually, by a physician, physician assistant or advanced nurse practitioner who is enrolled in accordance with 7 AAC 105.210 and is acting within the scope of that person's license;

(3) the items are medically necessary for a medical condition resulting in bladder or bowel incontinence;

(4) the recipient has not responded to, would not benefit from, or has failed bowel or bladder training; and

(5) the quantities prescribed do not exceed those established on the *Alaska Medicaid DMEPOS Fee Schedule* adopted by reference in 7 AAC 160.900; except

(6) subject to service authorization as required under 7 AAC 120.210, a provider may request and the department may pay for medically necessary incontinence supplies in quantities exceeding those on the *Alaska Medicaid DMEPOS Fee Schedule* adopted by reference in 7 AAC 160.900.

7 AAC 120.200(q) is repealed and readopted to read:

(q) In addition to meeting the requirements in 7 AAC 105.230, a recipient's medical record must contain documentation to substantiate the answers on the incontinence certificate of medical necessity prescription. A copy of the signed incontinence certificate of medical necessity prescription must be maintained in the recipient's medical record.

7 AAC 120.200 is amended by adding a new subsection to read:

(r) A provider enrolled under this section may not make unsolicited contact with a recipient of medical assistance under 7 AAC 100 for the purpose of marketing the provider’s products or services.

7 AAC 120.200 is amended by adding a new subsection to read:

(s) Prior to the receipt of a prescription order, written by the prescribing physician, physician assistant, or advanced nurse practitioner, a face-to-face examination as defined in federal regulation, 42 CFR 440, must occur no more than 6 months prior to the start of services and must be related to the primary reason that the recipient requires the durable medical equipment.

7 AAC 120.200 is amended by adding a new subsection to read

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

(1) the recipient's name and date of birth;

(2) the item being prescribed;

(3) the diagnosis;

(4) the quantity of item being prescribed;

(5) the directions or instructions for proper use of the item, including the frequency of use when applicable;

(6) the duration or estimated length of need for the item;

(7) the enrolled prescribing provider's signature and order signature date;

(8) the number of refills, if applicable; and

(9) the date of the face-to-face examination as required under federal regulation if prescribing durable medical equipment.

7 AAC 120.200 is amended by adding a new subsection to read:

(u) A prescription order for durable medical equipment, supplies and related items that require a certificate of medical necessity form may be part of the certificate of medical necessity, as long as the

certificate of medical necessity includes all of the components of a prescription order as described in subsection (t) including the diagnosis, international classification of disease code, length of need and the clinical assessment of need for prescribed services.

7 AAC 120.200 is amended by adding a new subsection to read:

(v) A certificate of medical necessity that contains a prescription order for durable medical equipment, prefabricated off-the-shelf orthotics, medical supplies and related items may not be prepared by a supplier of durable medical equipment, pre-fabricated orthotics, and medical supplies for the prescriber.

7 AAC 120.200 is amended by adding a new subsection to read:

(w) A prescription order, or prescription order that is part of a certificate of medical necessity, will be accepted from the signature date forward for no more than one year from the signature date unless otherwise defined by the prescriber. For the purposes of payment, a prescription order written and signed by the prescriber after a product has been dispensed will not be accepted for an item supplied prior to the dispensing provider receiving a valid prescription order.

7 AAC 120.200 is amended by adding a new subsection to read:

(*x*) The prescriber's wet 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 certificate of medical necessity by the prescriber. A signature stamp or a copy of a signature will not be accepted by the department as part of a valid prescription order even if affixed to the prescription order by the prescriber; a prescription order or certificate of medical necessity received via facsimile, with the prescriber's wet or authenticated digital signature, is acceptable.

7 AAC 120.205 is repealed and readopted to read:

7 AAC 120.205. Noncovered items and services.

(a) Except as provided otherwise in this section, the department will not pay separately for durable medical equipment while the recipient is

(1) in a hospital, a skilled nursing facility, or an intermediate care facility; or

(2) receiving hospice care services.

(b) The department will not pay separately for home infusion therapy services

(1) while the recipient is in a hospital, a skilled nursing facility, or an intermediate care facility;

(2) if like services, including skilled nursing visits, are provided by or under arrangements made by a home health agency;

(3) if, on the same day, like services are provided by a hospital or facility during an outpatient visit; or

(4) while the recipient is receiving hospice care services and the services are

(A) related to the treatment of the terminal illness that qualifies the recipient for hospice care; or

(B) provided by or under the arrangements made by the hospice program.

(c) The department will not pay for medical supplies or respiratory therapy assessment visits furnished to a recipient who is receiving hospice care services if the supplies or assessment visits are

(1) related to the treatment of the terminal illness that qualifies the recipient for hospice care; or

(2) provided by or under arrangements made by the hospice program.

(d) The department will not pay for the repair of durable medical equipment while the recipient is in a skilled nursing facility or an intermediate care facility.

(e) The department will not pay separately for the repair, return shipping, or preventive maintenance or service of durable medical equipment for which the cost of repair, return shipping, or preventive maintenance or service is included in the rental fee.

(f) The department will not pay for the repair, preventative maintenance or service of a DME item for which there is no documented medical necessity for the continued use of that item.

(g) The department will not pay providers enrolled under 7 AAC 120.200 for medical supplies that would result in a duplicate reimbursement situation, including personal protective equipment (e.g., gloves, masks, isolation gowns, etc.) that is required under federal rule and law to be provided at no cost to employees.

(h) For Medicare-Medicaid dual eligible recipients, DMEPOS providers must follow Medicare guidelines for mandatory and voluntary use of the Advance Beneficiary Notice of Noncoverage, Form CMS-R-131, in situations where Medicare payment is expected to be denied;

1. The department will not pay for durable medical equipment or supplies billed with codes exceeding the patient's medical necessity as determined by evidence-based clinical protocols and Medicare national and local coverage determinations;

2. The department will not pay more than 20% of the Medicare allowed rate for medically necessary wheelchairs suitable for use in the home if the provider indicates it will only be used in the community and the patient is unable to ambulate household distances and requires a wheelchair in the home;

3. The department will not pay for durable medical equipment for Medicare covered items (e.g., wheelchairs – manual or power) for a dual Medicare-Medicaid eligible recipient that Medicare has deemed medically unnecessary for that individual; providers must submit for the appropriate Medicare level of medical necessity and receive Medicare determination prior to seeking

payment from the department in excess of copay and deductible for Medicare-Medicaid dual eligible recipients;

(i) Providers may not bill for DMEPOS items using a miscellaneous HCPCS code if a specific HCPCS code is available and appropriate; if payment is erroneously made, the department may seek recovery under 7 AAC 105.260 of payment for those services or items and impose sanctions under 7 AAC 105.400 - 7 AAC 105.490.

(j) The department will not pay for DMEPOS items on the CMS "Required Prior Authorization List" in the Federal Register for which a prior (service) authorization has not been sought and approved.

(k) The department will not pay for DMEPOS items which require a face-to-face with the prescriber under if a face-to-face examination was not performed.

7 AAC 120.210(a) is repealed and readopted to read:

7 AAC 120.210. Service authorization.

(a) A provider seeking service authorization must make a request electronically or in writing on a certificate of medical necessity.

7 AAC 120.210(b) is repealed and readopted to read:

(b) Service authorization is required for

(1) the rental of durable medical equipment that is indicated as requiring service authorization on the *Alaska Medicaid DMEPOS Fee Schedules* adopted by reference in 7 AAC 160.900;

(2) medical supplies that exceed the maximum units or a 30-day limit set by the Department;

(3) customized durable medical equipment;

(4) items that are listed as requiring service authorization on the department's *Alaska Medicaid DMEPOS Fee Schedule*, adopted by reference in 7 AAC 160.900 or the *Alaska Medicaid DMEPOS Interim Fee Schedule*;

(5) items that are identified as miscellaneous in the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) *Healthcare Common Procedure Coding System (HCPCS)*, adopted by reference in 7 AAC 160.900;

(6) respiratory therapy assessment visits for ventilator-dependent recipients;

(7) home infusion therapy;

(8) enteral and oral nutritional products;

(9) The purchase of durable medical equipment for a recipient in a skilled nursing facility or intermediate care facility;

(10) Continuous oxygen for a recipient in a skilled nursing facility of an intermediate care facility;

(11) the purchase of durable medical equipment if the charge to the department is over $1,000;

(12) medical supplies and services if the charge to the department would result in more than $1,000 for a single claim or for a 30 day supply;

(13) wheelchairs and other durable medical equipment requiring prior authorization under federal Medicare regulation as outlined on the CMS "Required Prior Authorization List" maintained in the Federal Register;

(14) Medicare-covered durable medical equipment for a Medicare-Medicaid dual eligible recipient that Medicare has deemed medically unnecessary for that recipient including items denied by Medicare due to the item being used only in the community or provider seeking payment in excess of copay and deductible;

(15) Specialized power wheelchairs which require payment under capped rental rules where the DMEPOS provider requests direct purchase; and

(16) items that, based on medical necessity, may need to be replaced prior to the qualified time that the item would be allowed to be replaced otherwise and also may have not been identified, initially, as requiring a service authorization.

7 AAC 120.210(c) is repealed and readopted to read:

(c) A request for service authorization must be consistent with Medicare requirements where applicable and include, at a minimum,

(1) a prescription order with a certificate of medical necessity completed by the enrolled ordering

(A) physician;

(B) physician assistant; or

(C) advanced nurse practitioner;

(2) documentation by the person under (1) of this subsection that the item or service is necessary to treat, correct, or ameliorate a defect, condition, or physical or mental illness if the recipient is under 21 years of age; and

(3) for requests under (b)(2) and (b)(4) of this section for incontinence supplies an incontinence Certificate of Medical Necessity form completed by the recipient's ordering physician, physician assistant, or advanced nurse practitioner, on a form provided by the department, that includes the

(A) diagnosis, including the international classification of disease diagnosis code, that is related to the cause or is causing the incontinence of the bladder, bowels, or both;

(B) diagnosis, including the international classification of disease diagnosis code, of the type of incontinence;

(C) documentation that the recipient has not responded to, would not benefit from, or has failed bowel or bladder training for recipients ages 3 through 10 years;

(D) prognosis for controlling incontinence; and

(E) item or items to be dispensed;

(F) frequency of incontinence;

(G) duration of need;

(H) diuretic or other medications that increase output;

(I) products currently being used;

(J) skin integrity or vulnerability to skin breakdown;

(K) measurements for product sizes;

(L) quantity of item or items medically necessary;

(M) known allergies to product materials, when applicable; and

(N) description of abilities to manage incontinence independently or with assistance.

7 AAC 120.210(d) is repealed and readopted to read:

(d) In addition to the requirements of (c) of this section, a service authorization request for the following durable medical equipment or medical supplies 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:

(1) items that are identified as miscellaneous in the Healthcare Common Procedure Coding System (HCPCS), adopted by reference in 7 AAC 160.900;

(2) customized durable medical equipment; and

(3) items listed in section (c)(2) which must also include the product code and/or NDC, when applicable.

The editor's note following 7 AAC 120.210 is changed to read:

Editor's note: The certificate of medical necessity form referred to in 7 AAC 120.210(a) and (c) may be obtained from the Department of Health and Social Services, Division of Health Care Services, 4501 Business Park Boulevard, Building L, Anchorage, Alaska 99503-7167 or online at the Alaska Medicaid website www.medicaidalaska.com/providers/forms.html. Providers are advised to consult the PDAC resource, available at https://med.noridianmedicare.com/web/jddme/contact/pdac to ensure the appropriate HCPCS code is submitted for the product dispensed. The incontinence prescription form and the incontinence certificate of medical necessity form referred to in 7 AAC 120.210(c)(4) may be obtained from the Department of Health and Social Services, Division of Health Care Services, 4501 Business Park Boulevard, Building L, Anchorage, Alaska 99503 or online at the Alaska Medicaid website www.medicaidalaska.com/providers/forms.html.

7 AAC 120.215 is repealed and readopted to read:

7 AAC 120.215. Purchase of items.

(a) The department may authorize the purchase of new durable medical equipment, medical supplies, prefabricated off-the-shelf orthotics, and used durable medical equipment. The item becomes the property of the recipient for whom it is purchased. The enrolled provider shall

(1) transfer ownership of the item, including any warranty, to the recipient; and

(2) assure compliance with 7 AAC 120.215(j) if the item was previously used.

(b) The department will not authorize the purchase of an item that requires continuous rental under 7 AAC 120.225(a)(3).

7 AAC 120.215 is amended by adding a new section to read:

(c) The department will not reimburse in a single upfront payment the full cost of an item identified as a capped rental item under 7 AAC 120.215 on the *Alaska Medicaid DMEPOS Fee Schedule*, except medically necessary specialized power wheelchairs may be considered for direct purchase on a case-by-case basis through the service authorization process.

7 AAC 120.215 is amended by adding a new section to read:

(d) Rental of durable medical equipment identified as capped rental items on the department's *Alaska Medicaid DMEPOS Fee Schedule*, adopted by reference in 7 AAC 160.900, are considered purchased in full by the department after 10 months of continuous rental and ownership information, including warranties and title, must be transferred to the recipient on the first day after 10 months of continuous rental.

7 AAC 120.215 is amended by adding a new section to read:

(e) The 10 months of continuous rental begins when the recipient first receives the rental item and does not include temporary interruptions of less than 60 consecutive days, plus the days remaining in the rental month in which the use ceases. Unreimbursed months of temporary interruptions in rental do not count towards the 10 months of continuous rental or begin a new rental period.

7 AAC 120.215 is amended by adding a new section to read:

(f) Interruptions of greater than 60 consecutive days, plus the days remaining in the rental month in which the use ceases, will begin a new rental period and the provider must obtain a new prescription order and submit a new service authorization request for the new rental period.

7 AAC 120.215 is amended by adding a new section to read:

(g) Modification of the existing rental equipment due to a change in the recipient's medical needs during a 10 month continuous rental period does not begin a new rental period. The rental period for the existing equipment will continue and a new rental period for the added equipment will begin, if applicable.

7 AAC 120.215 is amended by adding a new section to read:

(h) Rental equipment that is replaced with different, but similar, equipment billed with the same HCPCS code during the 10 month continuous rental period will not begin a new rental period.

7 AAC 120.215 is amended by adding a new section to read:

(i) A temporary or permanent change in the recipient's residence during the 10 month continuous rental period will not begin a new rental period.

7 AAC 120.215 is amended by adding a new section to read:

(j) Providers enrolled under 7 AAC 120.200 may request payment for used or refurbished durable medical equipment at a rate of no more than 75 percent of the current established *Alaska Medicaid DMEPOS Fee Schedule* rate, according to 7 AAC 145.420, for rental or purchased items as long as the following criteria are met:

(1) the provider must have the recipient acknowledge in writing, and the provider must maintain documentation, that the recipient is receiving used equipment;

(2) the provider must bill with the appropriate modifier that distinguishes used equipment from new equipment;

(3) the used or refurbished equipment provided must be clean and sanitized;

(4) the product serial number must be included on the submitted claim; and

(5) the used or refurbished equipment provided must meet the current needs of the recipient, must be close to the manufacturer's suggested specifications for a newly purchased piece of equipment and be able to withstand at least 3 years of use; if the equipment supplied does not meet current replacement standards of three years of use and 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 to the department or the recipient except under provisions of 7 AAC 120.220(a).

7 AAC 120.220(a) is repealed and readopted to read:

7 AAC 120.220. Replacement of items.

(a) Subject to applicable requirements of 7 AAC 120.200 - 7 AAC 120.299, providers enrolled under this section may request a payment and the department may pay for the purchase or rental of replacement durable medical equipment and prefabricated off-the-shelf orthotics if the

(1) replacement is necessary to replace an item that has been in continuous use by the recipient for the item's reasonable useful lifetime and the department determines that the item is lost or irreparably damaged and the recipient has not required replacement of the product within the immediate three years due to abuse or neglect of the product;

(2) item is not covered by a manufacturer's warranty; and

(3) provider replaces the item with a like item, and if the original item was rented, continues renting the replacement in accordance with this chapter.

7 AAC 120.225(a) is repealed and readopted to read:

(a) Service authorization for the following rentals of durable medical equipment is required for:

(1) rental of items indicated as requiring service authorization on the *Alaska Medicaid DMEPOS Fee Schedules* adopted by reference in 7 AAC 160.900 for anticipated short-term use;

(2) capped rental of items indicated as requiring service authorization on the *Alaska Medicaid DMEPOS Fee Schedules* adopted by reference in 7 AAC 160.900;

(3) continuous rental of items indicated as requiring service authorization on the *Alaska Medicaid DMEPOS Fee Schedule*s adopted by reference in 7 AAC 160.900.

7 AAC 120.225(b) is repealed and readopted to read:

(b) Regardless of the type of rental under (a) of this section,

(1) the department will review the length of need for the item and its cost before authorizing payment for rental or purchase;

(2) the department will only pay the remaining portion of the full purchase price, not rental plus the full purchase price if the department deems it necessary to purchase the item instead of continuing to rent the item; the provisions of this paragraph do not apply to an item that is continuously rented under (a)(3) of this section;

(3) the cost of any necessary repair, return shipping, or maintenance is included in the rental fee; and

(4) when total rental payments reach the purchase price, except for an item that is continuously rented under (a)(3) of this section, repair is covered after 60 days or when the warranty expires, whichever is later.

7 AAC 120.225(c) is repealed and readopted to read:

(c) Subject to applicable requirements of 7 AAC 120.200 - 7 AAC 120.299, providers enrolled under this section may request payment and the department may pay for the capped rental of an item if the provider

(1) transfers ownership of the item, including any warranty, to the recipient for whom it was rented; and

(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 including 7 AAC 120.215(j) and 7 AAC 145.220.

7 AAC 120.225(d) is amended to read:

(d) The department will pay a provider by rental period. The department will not pay a provider for any **rental** item that exceeds **10** [12] months of continuous use, except for an item described in (a)(3) of this section.

7 AAC 120.225 is amended by adding a new subsection to read:

(e) Durable medical equipment providers enrolled under this section may request payment for medically necessary used or refurbished durable medical equipment and may be reimbursed at a rate of no more than 75 percent of the established *Alaska Medicaid DMEPOS Fee Schedule* new rate when a specific used rate is not listed, according to 7 AAC 145.420, for purchased items as long as the following criteria are met:

(1) the provider must have the recipient acknowledge in writing, and the provider must maintain documentation, that the recipient is receiving used equipment;

(2) the provider must bill with the appropriate modifier that distinguishes used equipment from new equipment;

(3) the provider must submit and maintain the item's serial number;

(4) the used or refurbished equipment provided must be clean and sanitized; and

(5) the used or refurbished equipment provided as rental equipment must meet the current medical needs of the recipient, must be close to the manufacturer's suggested specifications for a newly purchased piece of equipment and be able to withstand at least 3 years of use; if the equipment supplied does not meet current replacement standards of 3 years of use and 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 to the department or the recipient.

7 AAC 120.225 is amended by adding a new subsection to read:

(f) Providers enrolled under this section are not obligated to dispense used equipment; however, if used equipment is dispensed by a provider, the provider may not submit a claim reflecting new equipment was dispensed; otherwise the department may seek recovery under 7 AAC 105.260 of payment for those items and impose sanctions under 7 AAC 105.400 - 7 AAC 105.490.

7 AAC 120.225 is amended by adding a new subsection to read:

(g) The durable medical equipment provider enrolled under this section may not request payment for a claim for options, supplies and accessories that are considered included in the monthly rental payment nor will the department reimburse for options, supplies and accessories that are still considered to be covered by the manufacturer warranty.

7 AAC 120.230 is repealed and readopted to read:

7 AAC 120.230. Rental of items; changes during rental periods

(a) Except as otherwise provided in this section, an interruption in a rental period affects the department's payment as follows:

(1) a rental period is not affected by an interruption of less than 60 consecutive days plus the days remaining in the rental month in which the use ceases; if an interruption continues beyond 60 consecutive days plus the days remaining in the rental month in which use ceases, the department will pay for the rental month in which use ceased, but will not make an additional payment until use resumes and a new service authorization request is submitted and a new rental period begins;

(2) rental units for which service authorization has been received, but for which no payment is made, do not apply toward a capped rental period.

7 AAC 120.299 is repealed and readopted to read:

7 AAC 120.299. Definitions.

In 7 AAC 120.200 - 7 AAC 120.299,

(1) "capped rental" means the rental of durable medical equipment for no more than 10 months;

(2) "customized durable medical equipment" means durable medical equipment that is uniquely constructed or substantially modified for a specific recipient in accordance with the description and orders of a physician, a physician assistant, or an advanced nurse practitioner, and that is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes;

(3) "durable medical equipment" means equipment that

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to an individual in the absence of an illness or injury; and

(D) is appropriate for use in the home, school, or community;

(4) "medical supplies" means supplies that

(A) do not withstand repeated use;

(B) are primarily and customarily used to serve a medical purpose;

(C) generally are not useful to an individual in the absence of an illness or injury; and

(D) are appropriate for use in the home, school, or community;

(5) "miscellaneous" means an item or service listed in the Healthcare Common Procedure Coding System (HCPCS), adopted by reference in 7 AAC 160.900, that is

(A) described as "miscellaneous," "not otherwise classified," or "not otherwise specified"; or

(B) without a specific description or identifier;

(6) "Orthotic device" or "orthotic" means a corrective or supportive device that:

(A) Prevents or corrects physical deformity or malfunction; or

(B) Supports a weak or deformed portion of the body.

(7) “prefabricated off-the-shelf orthotics” means an orthotic that is manufactured in quantity without a specific patient in mind, requires minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling or customizing to fit a recipient;

(8) "prosthetic device" means a preventive, replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice under state law.

(9) “ reasonable useful lifetime” means the duration of time a piece of durable medical equipment is expected to perform as per manufacturer specifications without defect, generally three to five years.

(10) “substandard item” means an item that does not function in a manner that meets the prescribed need or specifications;

(11)"unnecessary utilization" means the furnishing of items that do not comply with one or more of Medicare's coverage, coding, and payment rules. (CMS-6050-F)

(12) “used equipment” means equipment that has been gently or lightly used, is in like new condition, is considered to be as close as possible to the original specifications of the manufacturer, and has an anticipated remaining usable life of approximately 3 years.

(13) "Warranty-period" means a guarantee or assurance, according to manufacturers' or provider's guidelines, of set duration from the date of purchase.

(14)"Wheelchair - Manual" - A federally approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

(A) Standard:

(1) Usually is not capable of being modified;

(2) Accommodates a person weighing up to two hundred fifty pounds; and

(3) Has a warranty period of at least one year.

(B) Lightweight:

(1) Composed of lightweight materials;

(2) Capable of being modified;

(3) Accommodates a person weighing up to two hundred fifty pounds; and

(4) Usually has a warranty period of at least three years.

(C) High-strength lightweight:

(1) Is usually made of a composite material;

(2) Is capable of being modified;

(3) Accommodates a person weighing up to two hundred fifty pounds;

(4) Has an extended warranty period of over three years; and

(5) Accommodates the very active person.

(D) Hemi:

(1) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and

(2) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

(E) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

(F) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

(G) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

(H) Heavy duty:

(1) Specifically manufactured to support a person weighing up to three hundred pounds; or

(2) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(I) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

(J) Custom heavy duty:

(1) Specifically manufactured to support a person weighing over three hundred pounds; or

(2) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(K) Custom manufactured specially built:

(1) Ordered for a specific client from custom measurements; and

(2) Is assembled primarily at the manufacturer's factory.

(L) "Wheelchair - Power" - A federally approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

(1) Custom power adaptable to:

(2) Alternative driving controls; and

(3) Power recline and tilt-in-space systems.

(4) Noncustom power: Does not need special positioning or controls and has a standard frame.

(M) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child, approximately 3 years.

(Eff. 2/1/2010, Register 193; am 1/1/2011, Register 196; am____/_____/_____, Register_____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

7 AAC 120 is amended by adding a new section to read:

7 AAC 120.300. Enrollment; general provisions; covered items and services.

(a) To be eligible for payment under 7 AAC 105 – 7 AAC 160 for providing prosthetics and orthotic devices and services, a provider must

(1) hold a valid business license issued under AS 43.70 and 12 AAC 12;

(2) be enrolled in accordance with 7 AAC 105.210 as a prosthetics and orthotics provider, regardless of whether the provider provides other items or services in (1) of this subsection, if the provider

(A) provides prosthetics and customized orthotics devices and services; and

(B) is accredited or certified by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics, the Board for Orthotist/Prosthetist Certification, the National Examining Board of Ocularists, Inc., or other similar certifying or accrediting agency approved by the department demonstrating applicable professional standards and qualifications; and

(C) employs at least one individual who maintains the credentials of Certified Orthotist (CO), Certified Prosthetist (CP), Certified Prosthetist/Orthotist (CPO), or Certified Pedorthist (C.PED) and serves as "in-charge;"

(3) provide to the department evidence that the provider is enrolled as a Medicare provider and Medicare enrollment is maintained concurrent with Medicaid enrollment.

(b) Subject to the applicable provisions of 7 AAC 120.300 - 7 AAC 120.399, prosthetics and orthotics providers enrolled under this section may request payment for prosthetic or orthotic devices and services furnished to a recipient, if

(1) the item is

(A) prescribed by a physician, physician assistant, or advanced nurse practitioner who is enrolled in accordance with 7 AAC 105.210 and acting within the scope of that person's license;

(B) appropriate for use in the recipient's home or community;

(C) not provided by, or under arrangements made by, a home health agency; or

(D) a repair or modification of a recipient's current prosthesis and all of the following are met:

(i) All warranties are expired;

(ii) The cost of the repair or modification is less than fifty percent of the cost of a new prosthesis and the provider has submitted supporting documentation; and

(iii) The repair has a warranty for a minimum of ninety days.

(c) A provider of Prosthetics and Orthotics shall

(1) ensure recipient is eligible to receive the product

(2) maintain proof of receipt for items supplied to recipients consistent with 7 AAC 105.230; the provider shall submit the proof of receipt to the department upon request; and

(3) accept returns of any substandard item;

(d) Due to the complexity of the details required for prosthetics and custom fabricated orthotics, a Certificate of Medical Necessity may be prepared by the supplier of Prosthetics and Custom Fabricated Orthotics if

(1) the prosthetic or custom fabricated orthotic is prescribed by the recipient's physician prior to the completion of the certificate of medical necessity by the prosthetics and orthotics supplier;

(2) the Certificate of Medical Necessity is reviewed and signed by the recipient's prescribing provider acknowledging concurrence with treatment plan;

(3) documentation of the certificate of medical necessity is maintained in the recipient's medical record by the recipient's prescribing provider.

(e) An order for a prosthetic or orthotic device must include the following:

(1) recipient's name and date of birth;

(2) item being prescribed;(3) diagnosis;

(4) quantity of the item being prescribed;

(5) duration or estimated length of need for the item; and

(6) enrolled prescribing provider's signature and order signature date.

(f) The Certificate of Medical Necessity (CMN) may serve as the prescription order for a prosthetic or orthotic device provided that it includes all of the components of a valid order, to include, at

minimum, diagnosis, international classification of disease code, length of need and clinical assessment of need for the prescribed services.

(g) A prescription order for a prosthetic or orthotic device or service, including a certificate of medical necessity serving as a prescription order, will be accepted from the signature date forward for no more than one year from the signature date unless otherwise defined by the prescriber. A backdated order will not be accepted as authorization for an item supplied prior to the provider receiving a valid prescription order for the item. A retroactive start date for a prescription order, with current day signature, may be considered upon individual medical necessity retrospective service authorization review provided all other state and federal regulatory provisions are met. If a retrospective start date is permitted, the prescription order will not be valid beyond one year from the retrospective start date.

(h) The prescriber's wet or authenticated digital signature must be made and affixed to the prescription order or the certificate of medical necessity serving as a prescription order by the prescriber. A signature stamp or a copy of a signature will not be accepted by the department as part of a valid prescription order even if affixed to the prescription order by the prescriber; a prescription order and/or certificate of medical necessity received via facsimile, with the prescriber's signature, is acceptable.

(i) Providers enrolled under this section may request payment for the reasonable and necessary direct costs of delivery or shipping prosthetics or orthotics incurred by the dispensing provider when using the most cost-effective means.

(1) To be eligible for payment, the following conditions must apply

(A) the recipient resides outside the municipality where the business of the enrolled dispensing provider is located, 50 air miles.

(B) the item or service is unavailable from a provider enrolled under this section in the municipality in which the recipient resides, defined as within 50 air miles.

(2) When the charge submitted by the provider exceeds $50, the claim and supporting documents must include

(A) the recipient's name;

(B) the address to where the item was delivered;

(C) an itemized list of the products included in the shipment or delivery, to include product name, product identifier, quantity, and serial number, when applicable;

(D) the shipment and delivery date;

(E) the recipient's signature with date of receipt;

(F) the total charges minus all discounts, substantiated by a paid shipping invoice reflecting the actual payment.

(j) The department will not pay separately for the costs of administrative expenses. The following costs are considered administrative expenses and are included in the payment for prosthetics and orthotics:

(1) telephone responses to questions;

(2) mileage;

(3) travel expenses;

(4) travel time;

(5) setting up an item;

(6) installation;

(7) orientation and training regarding the proper use of the item;

(8) preparation and maintenance of necessary records required under 7 AAC 105.230 and 7 AAC 120.210.

(k) The department may enter into a contract under AS 36.30, a grant, or other arrangement permitted by law, with a provider authorizing that provider to provide prosthetics or orthotics.

(*l*) A provider enrolled under this section may not make unsolicited contact with a recipient of medical assistance under 7 AAC 100 for the purpose of marketing the provider's products or services.

(m) Providers enrolled under this section may request payment for the reasonable and necessary costs of follow-up fittings and adjustments on a per 15 minute basis unless these services were included in and previously reimbursed under a bundled rate.

7 AAC 120.305. Noncovered items and services.

(a) The department will not pay separately for the repair, return shipping, or preventive maintenance or service of prosthetics or orthotics for which the cost of repair, return shipping, or preventive maintenance or service is included in the rental fee or warranty.

7 AAC 120.310. Service authorization.

(a) A provider seeking service authorization must make a request electronically or in writing on a certificate of medical necessity.

(b) Service authorization is required for

(1) items or services indicated as requiring service authorization on the *Alaska Medicaid DMEPOS Fee Schedule*s, including prosthetic or orthotic items or services, adopted by reference in 7 AAC 160.900;

(2) medical supplies that exceed the maximum units or a 30-day limit set by the Department;

(3) items that are identified as miscellaneous in the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS), adopted by reference in 7 AAC 160.900;

(4) prosthetic or orthotic items or services if the charge to the department is over $10,000; and

(5) items that, based on medical necessity, may need to be replaced prior to the qualified time that the item would be allowed to be replaced otherwise and also may have not been identified, initially, as requiring a service authorization.

(c) A request for service authorization must be consistent with Medicare requirements where applicable and include, at a minimum,

(1) a prescription order with a certificate of medical necessity completed by the enrolled ordering

(A) physician;

(B) physician assistant; or

(C) advanced nurse practitioner; and

(2) documentation by the person under (1) of this subsection that the item or service is necessary to treat, correct, or ameliorate a defect, condition, or physical or mental illness if the recipient is under 21 years of age.

The editor's note following 7 AAC 120.210 is changed to read:

Editor's note: The certificate of medical necessity form referred to in 7 AAC 120.310(a), (b), and (c) may be obtained from the Department of Health and Social Services, Division of Health Care Services, 4501 Business Park Boulevard, Building L, Anchorage, Alaska 99503-7167 or online at the Alaska Medicaid website www.medicaidalaska.com/providers/forms.html .

7 AAC 120.399. Definitions.

In 7 AAC 120.300 - 7 AAC 120.399,

(1) "custom fabricated orthotics" means an orthotic that is individually made for

a specific patient and created using an impression generally by means of plaster or fiber cast, a digital image using computer-aided design-computer aided manufacture (CAD-CAM) systems software, or direct form to patient;

(2) "customized durable medical equipment" means durable medical equipment that is uniquely constructed or substantially modified for a specific recipient in accordance with the description and orders of a physician, a physician assistant, or an advanced nurse practitioner, and that is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes;

(3) "durable medical equipment" means equipment that

(A) can withstand repeated use;

(B) is primarily and customarily used to serve a medical purpose;

(C) generally is not useful to an individual in the absence of an illness or injury; and

(D) is appropriate for use in the home, school, or community;

(4) "in-charge" means the professional (CO, CP, CPO, C.PED) who has the authority and responsibility for the facility's compliance with practice standards at the enrolled provider location.

(5) "medical supplies" means supplies that

(A) do not withstand repeated use;

(B) are primarily and customarily used to serve a medical purpose;

(C) generally are not useful to an individual in the absence of an illness or injury; and

(D) are appropriate for use in the home, school, or community;

(6) "minimal self-adjustment" means an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform; and that does not require the services of a certified

orthotist (that is, an individual who is certified by the American Board of Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training;

(7) "miscellaneous" means an item or service listed in the Healthcare Common Procedure Coding System (HCPCS), adopted by reference in 7 AAC 160.900, that is

(A) described as "miscellaneous," "not otherwise classified," or "not otherwise specified"; or

(B) without a specific description or identifier;

(8) "Orthotic device" or "orthotic" means a corrective or supportive device that:

(A) Prevents or corrects physical deformity or malfunction; or

(B) Supports a weak or deformed portion of the body.

(9) "Prosthetic device" means a preventive, replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice under state law.

(10) “substandard item” means an item that does not function in a manner that meets the prescribed need or specifications;

(11) "Warranty-period" means a guarantee or assurance, according to manufacturers' or provider's guidelines, of set duration from the date of purchase.

Chapter 145. Medicaid Payment Rates.

Sec 420. Durable medical equipment, supplies, prosthetics, orthotics and respiratory therapy payment rates.

7 AAC 145.420. Durable medical equipment, supplies, prosthetics, orthotics and respiratory therapy payment rates.

7 AAC 145.420(a) is repealed and readopted to read:

(a) Payment by the department to providers enrolled under 7 AAC 120.200 providing items and services to recipients will be in accordance with 7 AAC 145.020;

7 AAC 145.420(b) is repealed and readopted to read:

(b) Providers enrolled under 7 AAC 120.200 providing durable medical equipment, medical supplies, and prefabricated off-the-shelf orthotics to eligible Alaska Medicaid recipients may submit claims for covered HCPCS for which a rate or rate methodology has been established by CMS or the department or for covered codes with rate setting methodologies defined in (c) through (e).

(1) Payment rates set by the department for items and services provided by enrolled providers to recipients physically located in this state will be based on 100 percent of the current quarter's Medicare DMEPOS Fee Schedule established by CMS for these items and services in this state.

(2) Payment rates set by the department for items and services provided by enrolled providers who provide services to recipients when the recipient is physically located outside of this state will be based on 100 percent of the current quarter's Medicare DMEPOS Fee Schedule established by CMS for these items and services in the state where the item or service was provided.

(3) Payment rates set by the department for items and services not established on the current quarter's Medicare DMEPOS Fee Schedule will be based on the methodology outlined in (c) through (f) of this section.

7 AAC 145.420(c) is repealed and readopted to read:

(c) Payment rates for durable medical equipment, medical supplies, and prefabricated off-the-shelf orthotics for covered non-miscellaneous HCPCS codes for which CMS has not issued a rate on the current quarter's Medicare DMEPOS Fee Schedule as described in (b) of this section or the department has not established a rate and published on the *Alaska Medicaid DMEPOS Fee Schedule* or *Alaska*

Medicaid DMEPOS Interim Fee Schedule will be based on the submitted unaltered final purchase invoice price plus 35 percent until a rate is set by CMS or the department.

(1) The department will set a rate for a covered, non-priced, non-miscellaneous HCPCS code when at least 10 claims have been paid at the submitted unaltered final purchase invoice price plus 35 percent, and one or more claims have been paid to at least two different enrolled providers, the department will assign a rate for a covered non-miscellaneous code based on the following:

(A) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for first 10 claims is less than $5,000, the rate will be the median submitted unaltered final purchase invoice price of the first 10 claims plus 35 percent; if more than 15 claims are paid at the submitted unaltered final purchase invoice price plus 35 percent because claims had not been paid to at least two different enrolled providers for a particular HCPCS code, then the rate will be set at the median submitted unaltered final purchase invoice price of the number of claims paid between the effective date of this section and the date the rate is established plus 35 percent;

(B) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for the first 10 claims is $5,000 or more, the final rate set will be the median submitted unaltered final purchase invoice price plus 30 percent; if more than 15 claims are paid at the submitted unaltered final purchase invoice price plus 35 percent because claims had not been paid to at least two different enrolled providers for a particular HCPCS code, then the rate will be set at the median submitted unaltered final purchase invoice price of the number of claims paid between the effective date of this section and the date the rate is established plus 30 percent;

(2) when applicable, the rental rates for a covered item for which CMS or the department has not issued a permanent rate, the rate established for a covered non-miscellaneous code under this section will be 10 percent of the rate outlined in (c)(1);

(3) all claims paid under this subsection must be submitted with an unaltered final purchase invoice, as defined in 7 AAC 145.420(p), with the claim; claims submitted without an unaltered final purchase invoice or with anything other than an unaltered final purchase invoice will be denied;

7 AAC 145.420(d) is repealed and readopted to read:

(d) Payment rates for covered items submitted using a miscellaneous HCPCS code as defined in 7 AAC 120.299 for which CMS or the department has not issued a rate as described in (b) of this section will be paid at the unaltered final purchase invoice price plus 20%;

(1) No generic rate will be established for the miscellaneous HCPCS code, but the department shall reserve the right to set a rate based off National Drug Code or other product identifier and require the unique identifier to be submitted on claims to facilitate payment;

(2) Claims submitted for miscellaneous HCPCS codes under this section for which a product specific rate has not been established and published on the *Alaska Medicaid DMEPOS Fee Schedule* or *Alaska Medicaid DMEPOS Interim Fee Schedule* must be submitted with an unaltered final purchase invoice as defined in 7 AAC 145.420(p) with the claim; claims submitted without an unaltered final purchase invoice or with anything other than an unaltered final purchase invoice will be denied;

(3) when applicable, for a covered item defined under a miscellaneous code for which CMS or the department has not issued a price, the rental rate 10 percent of the purchase invoice price plus 20%;

7 AAC 145.420(e) is repealed and readopted read:

(e) rates established by the department under this section for a covered code for which CMS has not issued a rate may be published on the department's *Alaska Medicaid DMEPOS Interim Fee Schedule*.

7 AAC 145.420(f) is repealed and readopted to read:

(f) Providers enrolled under 7 AAC 120.200 may submit claims for labor and repair parts for damaged durable medical equipment, medical supplies, and pre-fabricated off-the-shelf orthotics with the following limitations:

(1) the department will not pay more than the corresponding labor rate listed on the *Alaska Medicaid DMEPOS Fee Schedule*, for which CMS has issued a price, adopted by reference in 7 AAC 160.900 for each 15 minutes of labor costs;

(2) the billing for a repair part must reflect a charge that complies with the applicable standards in 7 AAC 145.020 and this section;

(3) labor and repair parts for the item must be documented and the documentation must be submitted with each claim; documentation must include

(A) a statement signed by the recipient or the recipient's authorized representative that describes the cause for and nature of the repair;

(B) a description of the item being repaired and its serial number, if available;

(C) the beginning and end dates of warranty coverage, if available;

(D) 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; and

(E) an itemized list of parts used in repair and associated costs.

(4) A provider may not submit a claim for 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;

(5) a provider may not submit a claim for labor and repair parts for a rented item; the provider shall ensure that a rented item functions as intended after the provider repairs or replaces the item.

7 AAC 145.420(g) is repealed and readopted to read:

(g) A provider enrolled under 7 AAC 120.200 may submit claims and payment will be determined based on the *Alaska Medicaid DMEPOS Fee Schedules* adopted by reference in 7 AAC 160.900 for the following incontinence supplies up to the allowed quantities listed on the Alaska Medicaid DMEPOS Fee Schedule, except if a service authorization has been approved to exceed the allowed quantities based on medical necessity:

(1) garments;

(2) liners;

(3) under pads;

(4) nonsterile gloves;

(5) diaper wipes;

(6) disposable washcloths.

7 AAC 145.420(h) is repealed and readopted to read:

(h) For a rental period that is 30 days or more, the department will pay for rented durable medical equipment at the lesser of a monthly rental rate of 10 percent of the allowed purchase rate under this section or the billed rental charge, except

(1) HCPCS codes defined as rental codes or with a specific rental rate identified on the Alaska Medicaid DMEPOS Fee Schedule may pay at the rental price listed on the *Alaska Medicaid DMEPOS Fee Schedule* adopted by reference in 7 AAC 160.900 or the *Alaska Medicaid DMEPOS Interim Fee Schedule*;

(2) capped rental items may pay at the rental rate listed on the *Alaska Medicaid DMEPOS Fee Schedule* adopted by reference in 7 AAC 160.900 or the *Alaska Medicaid DMEPOS Interim Fee Schedule* up to the lesser of the purchase price of the item or 10 months of continuous rental.

7 AAC 145.420(i) is repealed and readopted to read:

(i) For a rental period that is less than 30 days, the department will pay for rented durable medical equipment at a monthly rental rate of 150 percent of the monthly fee in (g) of this section, 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 Fee Schedule* will pay at the lesser of the rental price listed on the *Alaska Medicaid DMEPOS Fee Schedule* adopted by reference in 7 AAC 160.900, the *Alaska Medicaid DMEPOS Interim Fee Schedule*, or the billed rental rate.

7 AAC 145.420 is amended by adding a new subsection to read:

(j) A provider enrolled under 7 AAC 120.200 may submit claims and payment may be authorized at a rate higher than the state-based rate published on the *Alaska Medicaid DMEPOS Fee Schedule* adopted by reference under 7 AAC 160.900 for a more costly medically necessary durable medical equipment, prefabricated off-the-shelf orthotic, or supplies if the recipient's medical condition substantiates the need and documentation is submitted with the claim that demonstrates that a less expensive product is not available to meet the medical needs of the recipient.

(1) Providers may request a higher reimbursement rate by submitting the alternate reimbursement rate request form (available on the department website) with the claim and the required documentation with the claim;

(2) Approved requests shall be reimbursed at the actual acquisition cost, as substantiated by a submitted final, unaltered invoice as outlined in 7 AAC 145.420(p), plus

(A) 35% for items with an actual acquisition cost below $5,000 or

(B) 30% for items with an actual acquisition cost at or above $5,000.

(3) Enteral nutrition (B code) and incontinence supplies (T code) are not eligible for higher reimbursement rates beyond those published on the *Alaska Medicaid DMEPOS Fee Schedule* adopted by reference in 7 AAC 160.900 or the *Alaska Medicaid DMEPOS Interim Fee Schedule.*

7 AAC 145.420 is amended by adding a new subsection to read:

(k) Subject to the applicable provisions of 7 AAC 120.200 – 7 AAC 120.299, a provider enrolled under 7 AAC 120.200 may request payment for the reasonable and necessary direct costs of delivery or shipping of the following:

(1) from the manufacturer to the provider for customized durable medical equipment 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; the shipping method used must be the most cost effective method available; 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 item in addition to the repair or replacement part, the department 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; expedited, next day, rush, or delivery charges resulting from the use of a shipping method other than the most cost effective method available will not be covered;

(2) From the dispensing provider to the recipient when the following conditions apply:

(A) the recipient resides outside the municipality where the business of the enrolled dispensing provider is located, defined as 50 air miles.

(B) the item or service is unavailable from a provider enrolled under this section in the municipality where the recipient resides, defined as within 50 air miles.

(C) the submitted claim and supporting documents must include:

(1) the recipient's name

(2) the address to where the item was delivered

(3) an itemized list of the products included in the shipment or elivery, to include product name, product identifier, quantity, and serial number, when applicable;

(4) the shipment and delivery date;

(5) the recipient's signature with date of receipt;

(6) the total charges minus all discounts, substantiated by a paid shipping invoice reflecting the actual payment

(3) From the recipient to the dispensing provider for the repair of recipient owned equipment when the following conditions apply:

(A) the recipient resides outside the municipality where the business of the enrolled dispensing provider is located, defined as 50 air miles

(B) repair services are unavailable from a provider enrolled under this section in the municipality where the recipient resides, defined as within 50 air miles

(C) the submitted claim and supporting documents must include:

(1) the address to where the item was delivered

(2) an itemized list of the products included in the shipment or delivery, to include product name, product identifier, quantity, and serial number, when applicable;

(3) the shipment and delivery date;

(4) the recipient's signature with date of receipt;

(5) the total charges minus all discounts, substantiated by a paid shipping invoice reflecting the actual payment

(D) shipping costs that qualify for coverage under this section due to the recipient traveling within or outside of this state are eligible for coverage if the recipient is 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; shipping costs related to recreational travel are not covered.

7 AAC 145.420 is amended by adding a new subsection to read:

(*l*) Used or refurbished durable medical equipment will be reimbursed at no more than 75 percent of the allowed rate for the specific item as defined in 7 AAC 145.420(b) – (e).

7 AAC 145.420 is amended by adding a new subsection to read:

(m) Enteral nutrition products (B code) and incontinence supplies (T code) 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 Fee Schedule adopted by reference in 7 AAC 160.900 to be eligible for payment; enteral product and incontinence supply reimbursement will be consistent with 7 AAC 145.020 and are not eligible for higher allowable adjustment requests.

7 AAC 145.420 is amended by adding a new subsection to read:

(n) Providers may use the department's price research form to request formal research of a state-based specific price established by the department that has not been established by CMS using the Alaska Medicaid DMEPOS Price Research Form.

7 AAC 145.420 is amended by adding a new subsection to read:

(o) An unaltered final purchase invoice is considered altered if

(1) any information on the original invoice is removed, erased, redacted, omitted, or otherwise modified so that the copy submitted to the department is anything other than an exact copy of the original invoice received by the enrolled provider from their supplier; legible markings made by an enrolled provider on the original invoice as part of their normal business practices will not result in the department viewing an invoice as altered so long as the markings do not remove, erase, redact, omit, or otherwise modify the invoice in any way that results in any of the information on the original invoice becoming illegible and the markings appear on both the original invoice and the copy submitted to the department;

(2) the invoice shows a price other than the final price paid by the enrolled provider.

7 AAC 145.420 is amended by adding a new subsection to read:

(p) *Alaska Medicaid DMEPOS Fee Schedules* will be available quarterly in accordance with published CMS Medicare DMEPOS fee schedules.

Editor's note: Quarterly current and historical *Centers for Medicare & Medicaid Services Medicare DMEPOS Fee Schedules* are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

7 AAC 145.420 is amended by adding a new subsection to read:

(q) In this section,

(1) "out-of-state" means provider is physically located in a state other than Alaska;

(2) "in-state" means the provider is physically located in the state of Alaska.

(Eff. 2/1/2010, Register 193; am 7/7/2010, Register 195; am_ / / , Register)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

The editor's note following 7 AAC 145.420 is changed to read:

Editor's note: The department's *Alaska Medicaid DMEPOS Interim Fee Schedule* and Alaska Medicaid DMEPOS Price Research Form, referenced in 7 AAC 145.420, may be obtained from the Department of Health and Social Services, Division of Health Care Services,4501 Business Park Boulevard, Building L, Anchorage, Alaska 99503-7167, or at http://www.medicaidalaska.com/providers/FeeSchedule.asp and www.medicaidalaska.com/providers/forms.html.

7 AAC 145 is amended by adding a new section to read:

7 AAC 145.421. Prosthetics and orthotics payment rates.

(a) Payment by the department to providers enrolled under 7 AAC 120.300 providing items and services to recipients will be in accordance with 7 AAC 145.020;

(b) Providers enrolled under 7 AAC 120.300 providing prosthetics or orthotics to eligible Alaska Medicaid recipients may submit claims for covered HCPCS for which a rate has been established by CMS or the department or for covered codes with rate setting methodologies defined in (c) through (e).

(1) Payment rates set by the department for items and services provided by enrolled providers to recipients physically located in this state will be based on 100 percent of the current quarter's Medicare DMEPOS Fee Schedule established by CMS for these items and services in this state.

(2) Payment rates set by the department for items and services provided by enrolled providers who provide services to recipients when the recipient is physically located outside of this state will be based on 100 percent of the current quarter's Medicare DMEPOS Fee Schedule established by

CMS for these items and services in the state where the item or service was provided. Location shall be based on the provider's Medicare accreditation location address.

(3) Payment rates set by the department for items and services not established on the current quarter's Medicare DMEPOS Fee Schedule will be based on the methodology outlined in (c) through (f) of this section.

(c) Payment rates for prosthetics and orthotics for covered non-miscellaneous HCPCS codes for which CMS has not issued a rate on the current quarter's Medicare DMEPOS Fee Schedule as described in (b) of this section or the department has not established a rate and published on the *Alaska Medicaid DMEPOS Fee Schedule* or *Alaska Medicaid DMEPOS Interim Fee Schedule* will be based on the submitted unaltered final purchase invoice price plus 35 percent until a rate is set by CMS or the department.

(1) The department will set a rate for a covered, non-priced, non-miscellaneous HCPCS code when at least 10 claims have been paid at the submitted unaltered final purchase invoice price plus 35 percent, and one or more claims have been paid to at least two different enrolled providers, the department will assign a rate for a covered non-miscellaneous code based on the following:

(A) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for first 10 claims is less than $5,000, the rate will be the median submitted unaltered final purchase invoice price of the first 10 claims plus 35 percent; if more than 15 claims are paid at the submitted unaltered final purchase invoice price plus 35 percent because claims had not been paid to at least two different enrolled providers for a particular HCPCS code, then the rate will be set at the median submitted unaltered final purchase invoice price of the number of claims paid between the effective date of this section and the date the rate is established plus 35 percent;

(B) if the median unaltered final purchase invoice price of the non-miscellaneous HCPCS item for the first 10 claims is $5,000 or more, the final rate set will be the median submitted

unaltered final purchase invoice price plus 30 percent; if more than 15 claims are paid at the submitted unaltered final purchase invoice price plus 35 percent because claims had not been paid to at least two different enrolled providers for a particular HCPCS code, then the rate will be set at the median submitted unaltered final purchase invoice price of the number of claims paid between the effective date of this section and the date the rate is established plus 30 percent;

(2) when applicable, the rental rates for a covered item for which CMS or the department has not issued a permanent rate, the rate established for a covered non-miscellaneous code under this section will be 10 percent of the rate outlined in (c)(1);

(3) all claims paid under this subsection must be submitted with an unaltered final purchase invoice, as defined in 7 AAC 145.421(p), with the claim; claims submitted without an unaltered final purchase invoice or with anything other than an unaltered final purchase invoice will be denied;

(d) Payment rates for covered items submitted using a miscellaneous HCPCS code as defined in 7 AAC 120.399 for which **CMS** or the department has not issued a rate as described in (b) of this section will be paid at the unaltered final purchase invoice price plus 20%, except when the covered item is a customized prosthetic or orthotic item manufactured under the oversight of and signed off by a certified professional outlined in 7 AAC 120.300(a)(2)(C);

(1) No generic rate will be established for the miscellaneous HCPCS code, but the department shall reserve the right to set a rate based off national product codes or other product identifier and require the unique identifier to be submitted on claims to facilitate payment;

(2) Claims submitted for miscellaneous HCPCS codes under this section for which a product specific rate has not been established and published on the *Alaska Medicaid DMEPOS Fee Schedule* or *Alaska Medicaid DMEPOS Interim Fee Schedule* must be submitted with an unaltered final purchase invoice as defined in 7 AAC 145.421(k) with the claim; claims submitted without an unaltered final purchase invoice or with anything other than an unaltered final purchase invoice will be denied;

(e) rates established by the department under this section for a covered code for which CMS has not issued a rate may be published on the department's *Alaska Medicaid DMEPOS Interim Fee Schedule*.

(f) Providers enrolled under 7 AAC 120.300 may submit claims for labor and repair parts for damaged prosthetics and orthotics with the following limitations:

(1) the department will not pay more than the corresponding labor rate listed on the *Alaska Medicaid DMEPOS Fee Schedule*, for which CMS has issued a price, adopted by reference in 7 AAC 160.900 for each 15 minutes of labor costs;

(2) the billing for a repair part must reflect a charge that complies with the applicable standards in 7 AAC 145.020 and this section;

(3) labor and repair parts for the item must be documented and the documentation must be submitted with each claim; documentation must include

(A) a statement signed by the recipient or the recipient's authorized representative that describes the cause for and nature of the repair;

(B) a description of the item being repaired and its serial number, if available;

(C) the beginning and end dates of warranty coverage, if available; and

(D) 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;

(E) an itemized list of parts used in repair and associated costs.

(1) A provider may not submit a claim for 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;

(2) a provider may not submit a claim for labor and repair parts for a rented item; the provider shall ensure that a rented item functions as intended after the provider repairs or replaces the item.

(g) Payment for miscellaneous HCPCS for custom-fabricated prosthetics and orthotics manufactured under the oversight of and signed off by a certified professional outlined in 7 AAC 120.300(a)(2)(C) will be based on the most applicable HCPCS at the lesser of :

(1) billed charges; or

(2) a price ceiling based on the following calculation:

(A) Itemized list of the cost of

(i) up to ten parts (for items with more than 10 parts) with no provider mark-up multiplied by 180%; or

(ii) itemized list of the cost of all parts used to manufacture the custom prosthetic or orthotic with no provider mark-up multiplied by 160%; plus

(A) labor charge priced at the L7520 payment rate per 15 minutes; plus

(B) additional costs (bundled) paid up to $1064.10; the bundled items include the initial evaluation, diagnostic checks and follow-up.

(h) Providers enrolled under 7 AAC 120.300 may request reimbursement for labor and parts costs associated with adjustments to a prosthetic medically necessary to prevent injury to the residual limb due to residual limb measurement changes that do not require a full new customized prosthetic.

(i) Subject to the applicable provisions of 7 AAC 120.300 – 7 AAC 120.399, a provider enrolled under 7 AAC 120.300 may request payment for the reasonable and necessary direct costs of delivery or shipping of the following:

(1) from the manufacturer to the provider for customized durable medical equipment 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; the shipping method used must be the most cost

effective method available; 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 item in addition to the repair or replacement part, the department 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; expedited, next day, rush, or delivery charges resulting from the use of a shipping method other than the most cost effective method available will not be covered;

(2) From the dispensing provider to the recipient when the following conditions apply:

(A) the recipient resides outside the municipality where the business of the enrolled dispensing provider is located, defined as 50 air miles.

(B) the item or service is unavailable from a provider enrolled under this section in the municipality where the recipient resides, defined as within 50 air miles.

(C) the submitted claim and supporting documents must include:

(i) the recipient's name

(ii) the address to where the item was delivered

(iii) an itemized list of the products included in the shipment or delivery, to include product name, product identifier, quantity, and serial number, when applicable;

(iv) the shipment and delivery date;

(v) the recipient's signature with date of receipt;

(vi) the total charges minus all discounts, substantiated by a paid shipping invoice reflecting the actual payment

(3) From the recipient to the dispensing provider for the repair of recipient owned equipment when the following conditions apply:

(A) the recipient resides outside the municipality where the business of the enrolled dispensing provider is located, defined as 50 air miles

(B) repair services are unavailable from a provider enrolled under this section in the municipality where the recipient resides, defined as within 50 air miles

(C) the submitted claim and supporting documents must include:

(i) the address to where the item was delivered

(ii) an itemized list of the products included in the shipment or delivery, to include product name, product identifier, quantity, and serial number, when applicable;

(iii) the shipment and delivery date;

(iv) the recipient's signature with date of receipt;

(v) the total charges minus all discounts, substantiated by a paid shipping invoice reflecting the actual payment

(4) shipping costs that qualify for coverage under this section due to the recipient traveling within or outside of this state are eligible for coverage if the recipient is 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; shipping costs related to recreational travel are not covered.

7 AAC 145.420 is amended by adding a new subsection to read:

(j) Providers may use the department's price research form to request formal research of a state-based specific price established by the department that has not been established by CMS using the Alaska Medicaid DMEPOS Price Research Form.

(k) An unaltered final purchase invoice is considered altered if

(1) any information on the original invoice is removed, erased, redacted, omitted, or otherwise modified so that the copy submitted to the department is anything other than an exact copy of the original invoice received by the enrolled provider from their supplier; legible markings made by an enrolled provider on the original invoice as part of their normal business practices will not result in the department viewing an invoice as altered so long as the markings do not remove, erase, redact, omit, or otherwise modify the invoice in any way that results in any of the information on the original invoice becoming illegible and the markings appear on both the original invoice and the copy submitted to the department;

(2) the invoice shows a price other than the final price paid by the enrolled provider.

7 AAC 145.420 is amended by adding a new subsection to read:

(*l*) Alaska Medicaid DMEPOS Fee Schedules will be available quarterly in accordance with published CMS Medicare DMEPOS fee schedules.

Editor's note: Quarterly current and historical Centers for Medicare & Medicaid Services Medicare DMEPOS Fee Schedules are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

The department's *Alaska Medicaid DMEPOS Interim Fee Schedule* and *Alaska Medicaid DMEPOS Price Research Form*, referenced in 7 AAC 145.420, may be obtained from the Department of Health and Social Services, Division of Health Care Services, 4501 Business Park Boulevard, Building L, Anchorage, Alaska 99503-7167, or at http://www.medicaidalaska.com/providers/FeeSchedule.asp and www.medicaidalaska.com/providers/forms.html.

7 AAC 145.420 is amended by adding a new subsection to read:

(m) In this section,

(1) "out-of-state" means provider is physically located in a state other than Alaska;

(2) "in-state" means the provider is physically located in the state of Alaska.

7 AAC 160.900(e) is amended to read:

(e) The following department fee schedules are adopted by reference:

(14) State Fiscal Year 2014 CPT Fee Schedule for Vision Services, and State Fiscal Year 2014 HCPC Fee Schedule for Vision Services, revised as of July 31, 2013**;** [.]

(15) Alaska Medicaid DMEPOS Fee Schedule Table I-5, revised as of October 10, 2017;

(16) Alaska Medicaid DMEPOS Fee Schedule Table I-6, revised as of October 10, 2017;

(17) Alaska Medicaid DMEPOS Fee Schedule Table I-7, revised as of October 10, 2017;

(18) Alaska Medicaid DMEPOS Fee Schedule Table I-8, revised as of October 10, 2017.

7 AAC 160.900 is amended by adding a new paragraph to read:

(f) the provisions of 42 C.F.R 424.57(c) (Application certification standards) federal statutes and regulations are adopted by reference:

(Eff. 2/1/2010, Register 193; am 8/25/2010, Register 195; am 12/1/2010, Register 196; am 1/1/2011, Register 196; am 1/15/2011, Register 197; am 2/9/2011, Register 197; am 3/1/2011, Register 197; am 10/1/2011, Register 199; am 12/1/2011, Register 200; am 1/26/2012, Register 201; am 3/8/2012, Register 201; am 4/1/2012, Register 201; add'l am 4/1/2012, Register 201; am 5/11/2012, Register 202; am

10/16/2012, Register 204; am 11/3/2012, Register 204; am 12/1/2012, Register 204; am 12/2/2012, Register 204; am 1/1/2013, Register 204; am 1/16/2013, Register 205; am 7/1/2013, Register 206; add'l am 7/1/2013, Register 206; am 11/3/2013, Register 208; am 1/1/2014, Register 208; am 2/2/2014, Register 209; am 3/19/2014, Register 209; am 3/22/2014, Register 209; am 5/18/2014, Register 210; am 2/26/2015, Register 213; am 3/15/2015, Register 213; am 7/1/2015, Register 214; am 5/1/2016, Register 218; am 6/16/2016, Register 218; am____/____/____, Register____)

Authority: AS 47.05.010 AS 47.07.030 AS 47.07.040

AS 47.05.012