Kansas
Medical Assistance
Program

July 2006 **Provider Bulletin Number 656**

DME Providers

Manual Updates

The following changes have been made to the *DME/Medical Supply Dealer Provider Manual*:

- Added a link to access the General Prior Authorization Request form
- Removed information regarding MediKan coverage
- Added the following forms to the Forms section:
  - Enteral Nutrition Prior Authorization Request
  - Manual Wheelchair Prior Authorization Request
  - Medical Necessity for Diabetes Testing Supplies
  - Power Wheelchair Prior Authorization Request
  - Pulse Oximeter Request
  - Special Seating Prior Authorization Request
  - Total Parenteral Nutrition (TPN) Prior Authorization Request

To view these changes, visit the Provider Manuals section of the KMAP Web site at https://www.kmap-state-ks.us.

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, please view the *DME/Medical Supply Dealer Provider Manual*, pages 7-1, 8-5, 8-21, AI-7, and the Forms section.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or (785) 274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

7000. DURABLE MEDICAL EQUIPMENT BILLING INSTRUCTIONS
Updated 7/06

Introduction to the HCFA-1500 Claim Form

DME providers must use the HCFA-1500 claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under the Kansas Medical Assistance Program. An example of the HCFA-1500 claim form is in the forms sections at the end of this manual. Instructions for completing this claim form are included in the following pages. The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

EDS does not furnish the HCFA-1500 claim form to providers. Refer to Section 1100 of the *General Introduction Manual*.

Accessing the General Prior Authorization Request Form

The General Prior Authorization Request Form and instructions for completing the form can be accessed from the KMAP Web site by following the path Publications, Forms or clicking on the following link: https://www.kmap-state-ks.us/Public/forms.asp

Complete, line by line instructions for completion of the HCFA 1500 are available in the *General Billing Manual*, pages 5-14 through 5-19.

SUBMISSION OF CLAIM:

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

BENEFITS AND LIMITATIONS

8300. Benefit Plan
Updated 7/06

KMAP beneficiaries will be assigned to one or more Medical Assistance benefit plans. The assigned plan or plans will be listed on the beneficiary ID card. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, contact the Medical Assistance Customer Service Center at 1-800-933-6593 or (785) 274-5990.

~~Only the following procedure codes are covered for MediKan beneficiaries. Refer to Appendices I, II and III for additional coverage requirements (PA, etc.).~~

~~Enteral and Parenteral Feeding Equipment and Supplies:~~

~~A4221~~	~~B4149-B4162~~	~~B4184~~	~~B4222~~	~~B9999~~
~~A4222~~	~~B4164~~	~~B4186~~	~~B5000~~	~~J7040~~
~~A4244~~	~~B4168~~	~~B4189~~	~~B5100~~	~~J7042~~
~~A4245~~	~~B4172~~	~~B4193~~	~~B5200~~	~~J7060~~
~~B4034-B4036~~	~~B4176~~	~~B4197~~	~~B9000-RR~~	
~~B4081-B4083~~	~~B4178~~	~~B4199~~	~~B9004-RR~~	
	~~B4180~~	~~B4216~~	~~B9998~~	

~~Life Support Medical Supplies:~~

~~Procedure codes under "Ostomy Supplies", "Other Medical Supplies", and "Urinary Equipment" as listed in Appendix II.~~

~~Oxygen and Oxygen Equipment:~~

~~E0424RR~~	~~E0443~~
~~E0431RR~~	~~E0444~~
~~E0434RR~~	~~E1390RR~~
~~E0439RR~~	~~E1391RR~~

~~Respiratory Accessories:~~

~~Suction Machine:~~

~~E0600-RR~~

8410. Updated 7/06

Miscellaneous Respiratory Supplies:

Flutter devices are limited to one unit every 365 days.

Swivel adaptors are limited to six units every 365 days.

Resuscitation bags are limited to one unit every 365 days.

Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler is limited to two units every 180 days.

Disposable filters for use with purchased aerosol compressors are limited to six units every 180 days. If compressor is rented, filters are content of service and should not be billed separately.

Nondisposable filters for use with purchased aerosol compressors are limited to one unit every 180 days. If compressor is rented, filters are content of service and cannot be billed separately.

Batteries, cables, and battery chargers for beneficiary-owned ventilators are limited to one unit every 365 days with prior authorization. If ventilator is rented, these items are content of service and cannot be billed separately.

Specialized Seating Equipment:

Specialized seating equipment is covered with approved PA for **non-institutionalized** KAN Be Healthy participants. (Refer to Section 4300.) Documentation from an approved KMAP seating clinic for medical necessity must be attached to the PA request.

A sign-off statement from the prescribing seating clinic will be required, indicating the seating clinic's recommended system has been provided. If statement is not received, claims will be subject to recoupment.

Used Equipment:

Rental of "used" DME is covered. Used DME may be purchased when it is determined by the Kansas Health Policy Authority (KHPA) ~~DHPF~~ to be more economical and in the best interest of KHPA ~~DHPF~~. Purchase of "used" DME will require PA.

Wheelchair Purchase:

Wheelchair purchase is limited to one per five years when repair to an existing wheelchair will exceed 75% of the allowance for a similar new model. **KAN Be Healthy** participants are exempt from this limitation.

RENTAL COV.	COV.	PROC. CODE	PURCH. COV.	Updated 7/06 NOMENCLATURE
				WALKERS
	NC	E0130	C	Walker, rigid (pickup), adjustable or fixed height
	NC	E0135	C	Walker, folding (pickup), adjustable or fixed height
	PA	E0148	PA	Walker, heavy duty, without wheels, rigid or folding, any type, each (Rental-per month)
	PA	E0149	PA	Walker, heavy duty, wheeled, rigid or folding any type
				COMMODE CHAIRS
	PA	E0168	PA	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each (Rental-per month)
				WHEELCHAIRS, MANUAL
	PA	K0001	PA	Standard wheelchair
	PA	K0002	PA	Standard hemi (low seat) wheelchair
	PA	K0003	PA	Lightweight wheelchair
	PA	K0004	PA	High strength, lightweight wheelchair
	PA	K0005	PA	Ultra lightweight wheelchair
	PA	K0006	PA	Heavy duty wheelchair
	PA	K0007	PA	Extra heavy duty wheelchair
	PA	K0009	PA	Other manual wheelchair base
KBH	NC	E1037	PA	Transport Chair, Pediatric size
KBH	PA	E1038	PA	Transport Chair, Adult size, patient weight capacity up to and include 300 pounds
~~KBH~~	PA	E1161	PA	Manual Adult size wheelchair, includes tilt in space
KBH	PA	E1231	PA	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system
KBH	PA	E1232	PA	Wheelchair, pediatric size, tilt-in-space, folding adjustable with seating system
KBH	PA	E1233	PA	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable without seating system
KBH	PA	E1234	PA	Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system
KBH	PA	E1235	PA	Wheelchair, pediatric size, rigid, adjustable, with seating system
KBH	PA	E1236	PA	Wheelchair, pediatric size, folding, adjustable, with seating system
KBH	PA	E1237	PA	Wheelchair, pediatric size, rigid, adjustable, without seating system
KBH	PA	E1238	PA	Wheelchair, pediatric size, folding, adjustable, without seating system

Kansas Medical Assistance Program

P.O. Box 3571
Topeka, KS 66601-3571
Provider Line: 1-800-933-6593
Beneficiary Line: 1-800-766-9012

From the office of the fiscal agent

ENTERAL NUTRITION PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date of Birth: _____/_____/_____

PROVIDER INFORMATION

Provider Name: _____ Provider Medicaid ID #: _____

Provider Contact Person: _____

Telephone Number: (_____)_____ Fax Number: (_____)_____

MEDICAL NECESSITY INFORMATION

1) Enteral nutrition diagnosis: _____

2) Does beneficiary live at home? Yes_____ No_____

3) Is home health involved with beneficiary's care? Yes_____ No_____

If so, which home health agency? _____ Phone #: (____)_____

4) Is enteral nutrition sole source of nutrition? Yes_____ No_____

If No, explain what other source of nutrition beneficiary is receiving and the approximate number of calories derived from additional source of nutrition.

_____

_____

5) Name of formula: _____ HCPCS code:_____

6) Calories per day from enteral nutrition: _____

7) Beneficiary's weight within last 30 days: _____ Date obtained: _____/_____/_____

8) What type of feeding tube does the beneficiary have in place? _____

9) Status of medical condition such as stable or declining: _____

10) Feeding kits requested: _____ HCPCS code: _____

11) If pump or pump supplies are being requested, indicate medical necessity: _____

_____

Fax completed forms to the Prior Authorization fax line: 1-800-913-2229 or (785) 274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
If this request is not received within 15 working days, PA will be denied.
Prior Authorization: 1-800-285-4978 or (785) 274-5499

Kansas Medical Assistance Program

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Beneficiary Line: 1-800-766-9012

From the office of the fiscal agent

Manual Wheelchair Prior Authorization Request Form

Provider #: _____

Provider Name, Address, and Phone #:

PA does not guarantee eligibility.
If service is noncovered by KMAP, PA is void.

PA does not override Primary Care Network (PCN) referral limitation.

PA does not override program limitations.

GENERAL BENEFICIARY INFORMATION

Beneficiary Medicaid ID #	Beneficiary Name (Last, First, MI)	Date of Birth

Diagnosis Description

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Date: ____/____/_____ Ht: _____ Wt: _____ Is condition stable? (circle) Yes No

Approved HCPCS code must be used for all requests: _____

Manufacturer Name: _____ Model: _____

The following items must be included with request:

___ Manufacturer retail pricing including wheelchair options (or invoice if renting a used in-stock wheelchair)
___ Warranty information
___ Signed/dated prescription including medical necessity for any wheelchair options being requested

(1) Wheelchair is being requested for: _____ Purchase _____Rental

(2) How long will the wheelchair be needed?_____

(3) Does the beneficiary need the wheelchair to be mobile? (circle) Yes No

(4) What distance can the beneficiary ambulate? _____(feet)

(5) Does beneficiary currently have a wheelchair? (circle) Yes No

(6) How many hours per day is the manual wheelchair used? _____

(7) What is the age of the current wheelchair and who purchased it?

_____

(8) What are the estimated repair costs or an explanation of why wheelchair cannot be repaired?

_____

_____

(Manual Wheelchair Prior Authorization Request Form continued)

(9) How has the beneficiary been managing without a wheelchair until now?

_____

_____

(10) What are the plans or options for beneficiary if wheelchair is not provided?

_____

_____

(11) If the beneficiary is receiving a RENTAL WHEELCHAIR is it:

_____Used (in stock) _____New

Will provider consider rental toward purchase of wheelchair? (circle) Yes No

(If yes, please include purchase price information with the request.)

The reimbursement approved includes the assembly of the wheelchair and all components of the wheelchair.

Wheelchair rental includes all repairs or modifications needed.

Provider Signature:_____ Date: ____/____/_____

Fax completed forms to the Prior Authorization fax line: 1-800-913-2229 or (785) 274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
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Prior Authorization: 1-800-285-4978 or (785) 274-5499

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Beneficiary Line: 1-800-766-9012

From the office of the fiscal agent

Physician Order Form
Medical Necessity for Diabetes Testing Supplies

(This form suffices as a script. Requests will not be considered without a PA request form completed by the DME provider, including use of appropriate HCPCS codes and modifiers.)

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____Date of Birth: _____/_____/_____

Diabetes ICD-9 Diagnosis Code

□ **250.01 type 1 (insulin dependent)** ***not stated as uncontrolled***

□ **250.03 type 1 (insulin dependent) uncontrolled**

□ **250.00 type 2 or unspecified type** ***not stated as uncontrolled***

□ **250.02 type 2 or unspecified type uncontrolled**

□ **648.8 gestational diabetes EDC: ____/____/_____**

□ **Other_____**

Physician Order for Blood Glucose Testing

- Testing frequency _____ times daily
- Length of need _____
- Diabetes being treated with insulin?
  - □ Yes ____ injections daily.
  - □ No, it is treated by _____

If testing exceeds KMAP's maximums, (one time daily if non-insulin treated; three times daily when insulin-treated) please provide this additional information:

Reason for greater frequency of testing is:

□ Fluctuating blood sugar □ Uncontrolled blood sugar □ Hypoglycemia

□ Other (explain): _____ _____

The additional test results will be used to: _____

_____

This patient has been seen, and I have evaluated the patient's control within the last six months: □ Yes □ No

Please print Physician Name: _____

Physician's KMAP Provider ID#: _____

Physician/ARNP/PA Signature: _____ Date: ____/____/_____

Fax completed forms to the Prior Authorization fax line: 1-800-913-2229 or (785) 274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
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Provider Line: 1-800-933-6593
Beneficiary Line: 1-800-766-9012

From the office of the fiscal agent

Power Wheelchair Prior Authorization Request Form

Provider #: _____

Provider Name, Address and Phone #:

PA does not guarantee eligibility.
If service is noncovered by KMAP, PA is void.

PA does not override Primary Care Network (PCN) referral limitation.

PA does not override program limitations.

GENERAL BENEFICIARY INFORMATION

Beneficiary Medicaid ID #	Beneficiary Name (Last, First, MI)	Date of Birth

Diagnosis Description

Ht: _____ Wt: _____ Is condition stable? (circle) Yes No

Approved HCPCS Code/Procedure Code: _____

Manufacturer Name: _____ Model: _____

Date of Service: From ____/____/_____ To ____/____/_____ Reimbursement Amt: $_____

The following information must be included with request:

___ Manufacturer retail pricing including wheelchair options (or invoice if renting a used, in-stock wheelchair)

___ Signed/Dated prescription including medical necessity for any wheelchair options being requested

___ Signed/Dated verification of school or work including the number of hours attending or working

(1) Is the beneficiary in an adult care facility? (circle) Yes No

(2) How long has the doctor indicated the wheelchair will be needed? _____(months)

(3) Does the beneficiary need the wheelchair to be mobile? (circle) Yes No

(4) What distance can the beneficiary ambulate? _____(feet)

(5) Does the beneficiary have a manual wheelchair? (circle) Yes No (Age:_____)

(6) How many hours per day is the manual wheelchair used? _____

(7) Can beneficiary operate the manual wheelchair without the help of attendant? (circle) Yes No

(Power Wheelchair Prior Authorization Request Form continued)

(8) How many hours per day will the power wheelchair be used? _____

(9) How many hours per day of attendant care? _____ What type of services were performed?_____

(10) Has beneficiary demonstrated ability to operate power wheelchair controls independently? (circle) Yes No

(11) Documentation must be provided that addresses why a manual wheelchair does not meet beneficiary's needs:

_____

_____

_____

(12) Provide written verification of number of hours beneficiary works or attends school.

_____

_____

_____

(13) How has the beneficiary been managing without a power wheelchair until now? What are the plans/options for beneficiary if a power wheelchair is not provided?

_____

_____

The reimbursement approved includes the assembly of the wheelchair and all components of the wheelchair.

Wheelchair rental includes all repairs or modifications needed.

Provider Signature:_____ Date: ____/____/_____

Fax completed forms to the Prior Authorization fax line: 1-800-913-2229 or (785) 274-5956.
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If this request is not received within 15 working days, PA will be denied.
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Beneficiary Line: 1-800-766-9012

From the office of the fiscal agent

PULSE OXIMETER REQUEST FORM

Requested for (circle one): **Rental** or **Purchase**
For (circle one): **E0445 Continuous use** or **Intermittent readings**
Type of Oximeter _____
Beneficiary Name: _____ Date of Birth: ____/____/_____
Beneficiary Medicaid ID #: _____ KAN Be Healthy Due: ____/____/_____
Provider Contact Name: _____ Phone Number: _____
Provider Medicaid ID #: _____

Estimated Length of Need:_____ Date Service Requested: ___/___/____ - ___/___/____
From Through

Diagnosis: _____

__ 1. Prescription must be kept on file by provider.

__ 2. Letter of medical necessity from the physician which includes *diagnosis and pertinent medical history* which *justifies the need for the device requested.*

__ 3. Written plan of care which documents **step-by-step** protocol to be used in case of desaturation. Copy must be sent with request: ___ and Copy kept in home: ___.

__ 4. Statement from physician, nurse, or case manager which verifies that the designated caregiver in the home is trained in above protocol. Caregiver must be capable of using device, documenting and maintaining record of results, and implementing appropriate interventions. Copy must be sent with request. _____

__ 5. Primary diagnosis and medical history must justify use of the device.

__ 6. Is beneficiary receiving oxygen? _____ Rate of O2 administration: _____

Is use: Continuous _____ Intermittent _____ During seizures, etc. _____

__ 7. There is professional oversight (physician, Home Health nurse, case manager) of the plan of care or medical treatment plan.

__ 8. Apnea monitor in the home and/or currently used by beneficiary? _____

__ 9. For **rental**, indicate if provider is willing to apply rent paid toward purchase price should long term need be indicated after six months: _____. **Two probes per month considered COS with rental**. Will additional probes be needed? _____

How many? _____ Price per probe: $_____

__ 10. For **purchase**, please supply: MSRP or provider's cost $_____.

Number of probes needed per month _____ and cost per probe $_____.

___ Warranty Information

___ Maintenance Requirements

___ Willing to apply past rental paid toward purchase price, and if so, how much? **$_____**

Provider Representative Signature:_____ Date: ___/___/_____

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Beneficiary Line: 1-800-766-9012

From the office of the fiscal agent

Special Seating Prior Authorization Request Form

Provider #: _____

Provider Name, Address, and Phone #:

PA does not guarantee eligibility.
If service is noncovered by KMAP, PA is void.

PA does not override Primary Care Network (PCN) referral limitation.

PA does not override program limitations.

GENERAL BENEFICIARY INFORMATION

Beneficiary Medicaid ID #	Beneficiary Name (Last, First, MI)	Date of Birth

Diagnosis Description

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Seating Clinic Evaluation (circle) Yes No Date: _____/_____/_____

Name of Seating Clinic: _____

Answer the following questions

(1) How many hours per day is the special seating needed? _____

(2) Will special seating be used for purchase or rental wheelchair? _____

(3) If power wheelchair:

a. Does the beneficiary have a manual wheelchair? (circle) Yes No

b. Will special seating be used interchangeably between power and manual? (circle) Yes No

(4) What are the plans or options for the beneficiary if special seating is not provided? _____
_____
_____
_____
_____

(Special Seating Prior Authorization Request Form continued)

	CODE	DESCRIPTION	MSR	REQUESTING
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				

The reimbursement approved includes all assembly of the special seating and attachment to the wheelchair.

Provider is responsible for providing the most current manufacturer suggested retail (MSR) pricing.

Date Service Requested: ____/____/_____

Provider Signature:_____ Date: ____/____/_____

Fax completed forms to the Prior Authorization fax line: 1-800-913-2229 or (785) 274-5956.
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From the office of the fiscal agent

TOTAL PARENTERAL NUTRITION (TPN)
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary Name: _____ Date of Birth: ____/____/_____

Beneficiary Medicaid ID #: _____

PROVIDER INFORMATION

Provider Name: _____ Provider ID #: _____

Provider Contact Person: _____ Telephone #: (_____)_____

MEDICAL NECESSITY INFORMATION

1) Parenteral nutrition diagnosis: _____

2) Does beneficiary live at home? Yes____ No____ If no, where does beneficiary live? _____

3) Is home health involved with beneficiary's care? Yes_____ No_____

If so, which home health agency? _____ Telephone #: (____)_____

4) Is parenteral nutrition sole source of nutrition? Yes_____ No_____

If No, explain what other source of nutrition beneficiary is receiving and approximate number of calories derived from additional source of nutrition.

_____

_____

5) Grams of protein per day: _____ HCPCS code: _____

6) Grams of lipids per day: _____ HCPCS code: _____

7) Calories per day from TPN: _____

8) Beneficiary's weight within last 30 days: _____ Date obtained: ____/____/_____

9) What type of parenteral catheter (such as hickman or port-a-cath) does the beneficiary have in place?

_____

10) Status of medical condition (such as stable or declining) _____

11) Length of time anticipated for use of TPN: _____

12) How often and what type of labs are being done? _____

Fax completed forms to the Prior Authorization fax line: 1-800-913-2229 or (785) 274-5956.
This form will be returned unprocessed if it is not completed in its entirety.
If this request is not received within 15 working days, PA will be denied.
Prior Authorization: 1-800-285-4978 or (785) 274-5499