Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers – Hyperalimentation**

DATE: **October 1, 2006**

SUBJECT: **Provider Manual Update Transmittal # 75**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
202.000	10-1-04	202.000	10-1-06
202.200	10-13-03	202.200	10-1-06
212.000	10-13-03	212.000	10-1-06
213.000	10-13-03	213.000	10-1-06
214.000	10-13-03	214.000	10-1-06
215.000	10-13-03	215.000	10-1-06
216.000	10-13-03	216.000	10-1-06
222.000	10-13-03	222.000	10-1-06
—	—	222.100	10-1-06
—	—	222.200	10-1-06
—	—	222.300	10-1-06
—	—	222.400	10-1-06
—	—	223.000	10-1-06
242.142	9-1-05	242.142	10-1-06

Explanation of Updates

Section 202.000 has been included to advise of the conditions necessary for the approval of the Medicaid application and contract.

Section 202.200 has been included to change the section heading to “Hyperalimentation Providers Enrollment in States Not Bordering Arkansas” and advise of the conditions necessary for the approval of closed-end services for those providers.

Section 212.000 has been included to advise of the requirements necessary to provide hyperalimentation services.

Section 213.000 has been included to advise that parenteral hyperalimentation services must be prior approved. Medical conditions that result in parenteral nutrition are also detailed.

Section 214.000 has been included to advise that enteral (sole source) hyperalimentation services must be prior approved. Medical conditions that result in enteral (sole source) nutrition are also detailed.

Section 215.000 has been included to advise that the Women Infants and Children's Program should be accessed first for individuals who are aged 0 to five years. Obsolete information has been removed from the section.

Section 216.000 has been included to clarify the documentation requirements for hyperalimentation providers.

Section 222.000 has been included to clarify the conditions that require a prior authorization or prior approval of services and to advise that the Arkansas Foundation for Medical Care, Inc. (AFMC) will perform prior authorizations for hyperalimentation services. The additions of rationale for prior authorization reconsideration or denials have been added to the section.

Section 222.100 has been created to include the approval process by AFMC for prior authorizations.

Section 222.200 has been created to include information about denials of prior authorization.

Section 222.300 has been created to include information about reconsideration requests.

Section 222.400 has been created to include information about fair hearing requests for beneficiaries and providers.

Section 223.000 has been created to include information about AFMC's pre-approval process for hyperalimentation services.

Section 242.142 has been included to clarify language regarding the conditions that warrant prior authorization for equipment and supplies necessary for the administration of enteral (sole source) nutrition.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

TOC required

202.000 Arkansas Medicaid Participation Requirements for Hyperalimentation Providers 10-1-06

Providers of parenteral and enteral (sole source) nutrition therapy services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

A. The provider must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Taxpayer Identification Number and Certification (Form W-9).**

B. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

C. The provider of parenteral nutrition must be licensed as a retail pharmacy by the Arkansas State Board of Pharmacy. A copy of the provider's current Arkansas Retail Pharmacy Permit must accompany the provider application and Medicaid contract. The provider must maintain a current Arkansas Retail Pharmacy Permit while providing services in this program. Subsequent licensure must be provided when issued.

D. The provider application and Medicaid contract must be approved by the Arkansas Medicaid Program.

E. Providers of both parenteral and enteral nutrition must be enrolled in the Title XVIII (Medicare) Program to provide hyperalimentation services. A copy of the Medicare letter of verification must accompany the application.

202.200 Hyperalimentation Providers Enrollment in States Not Bordering Arkansas 10-1-06

A. Hyperalimentation providers in states not bordering Arkansas may enroll in Arkansas Medicaid as closed-end providers only after they have treated an Arkansas Medicaid beneficiary and have a claim or claims to file. **View or print Provider Enrollment Unit contact information.**

1. Enrollment as a closed-end provider automatically expires after a year unless there is additional activity. See part B below.
2. To enroll, providers must download the provider manual and provider application materials from the Arkansas Medicaid website, **www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx**, and then submit the application and claim to the Medicaid Provider Enrollment Unit.

B. Closed-end providers remain enrolled for one year.

1. If a closed-end provider treats another Arkansas Medicaid beneficiary during its year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
2. During the enrollment period the provider may file any subsequent claims directly to the Arkansas Medicaid fiscal agent.
3. Closed-end providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

212.000 Scope 10-1-06

Hyperalimentation services are provided to beneficiaries at their place of residence. "Place of residence" is defined as the beneficiary's own dwelling, an apartment, a relative's home or a

boarding home. Hyperalimentation services in the beneficiary's place of residence may be covered only when the therapy is determined to be medically necessary for the patient and is prescribed by a physician.

Hospitalization is required to initiate parenteral and enteral, sole source nutrition.

Enteral (sole source) nutrition therapy must meet the criteria listed above and be the sole source of nutrition in order to be covered by Medicaid.

The request for prior authorization for therapy must be submitted on the form DMS-2615. **View or print form DMS-2615 and instructions for completion.** The prescribing physician must document the beneficiary's diagnosis and brief medical history that supports the medical necessity of the requested nutritional therapy services. The prescription must specify the frequency, the route, the product name, volume and duration of the requested nutritional therapy.

Documentation describing the beneficiary's or caregiver's training in catheter care; solution preparation and infusion technique to ensure the prescribed therapy can be provided safely and effectively in the beneficiary's place of residence must be available upon request.
Hospitalization is required to initiate parenteral and enteral, sole source nutrition.

The Arkansas Medicaid Program does not cover enteral (sole source) nutrition therapy hyperalimentation services for patients residing in a long term care facility. Enteral (sole source) nutrition therapy services are included in the per diem amount paid to long term care facilities. Arkansas Medicaid does cover parenteral nutrition therapy services through the Hyperalimentation Program for long term care facility residents.

213.000 Coverage of Parenteral Hyperalimentation Services/Benefit Limits 10-1-06

Daily parenteral nutrition is considered medically necessary for a patient with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition.

Hyperalimentation is delivery of nutrients through a central venous line. **Hyperalimentation is not a covered service when delivered through a peripheral IV.**

Coverage of parenteral nutrition therapy must be prior approved. Each request will be reviewed on a case by case basis. Some medical conditions that frequently cause severe nutritional deficiency, in spite of adequate oral intake, and result in the use of parenteral nutrition are:

A. Short bowel syndrome

B. Intestinal obstruction

C. Inflammatory bowel disease including ulcerative colitis and Crohn's disease

D. Motility disorder (pseudo obstruction)

E. Radiation enteritis

F. Mesenteric infarction

G. Massive bowel resection

Parenteral hyperalimentation services include the provision and delivery of the prescribed therapy, equipment and supplies necessary for the administration of the parenteral nutrition in the beneficiary's place of residence.

A nutritional assessment performed by the hyperalimentation provider is not a covered service.

Parenteral hyperalimentation services are limited to six units of service per day. A half-liter of the prescribed hyperalimentation total parenteral nutrition (TPN) equals one unit of service. Units may not be rounded up. Providers must bill a date span according to the prescribed daily volume. (Refer to Section 240.000 for billing instructions)

214.000 Coverage of Enteral (Sole Source) Hyperalimentation Services/Benefit Limits 10-1-06

Coverage of sole source enteral therapy must be prior approved. Enteral (sole source) nutrition is considered medically necessary for a patient with a functioning gastrointestinal tract who cannot maintain weight and strength commensurate with his or her general condition due to pathology or non-function of the structures that normally permit food to reach the digestive tract. Enteral (sole source) therapy may be given by nasogastric, jejunostomy or gastrostomy tubes.

Coverage of enteral (sole source) nutrition therapy must be prior approved. Each request will be reviewed on a case by case basis. Typical examples of conditions that would qualify for coverage are:

A. Acute ulcerative colitis

B. Gastrointestinal cancer

C. Granulomatous colitis

D. Intestinal atresia (infants)

E. Ischemic bowel disease

F. Malabsorption syndrome

G. Short-gut syndrome

H. Head and neck cancer with reconstructive surgery

I. Central nervous system disease leading to interference with the neuromuscular mechanisms of ingestion of such severity that the patient cannot be maintained with oral feeding.

Enteral (sole source) hyperalimentation services include the provision and delivery of the prescribed therapy, equipment and supplies necessary for the administration of the prescribed therapy in the beneficiary's place of residence.

Enteral (sole source) hyperalimentation services are limited to 30 units of service per day. One unit of service equals 100 calories of covered nutritional therapy product resulting in a maximum of 3000 calories per day. Units may not be rounded up. Providers must bill a date span according to the prescribed daily volume. (Refer to Section 240.000 for billing instructions.)

215.000 Exclusions 10-1-06

Hyperalimentation equipment and supplies will not be authorized for use by a beneficiary in an institution not defined as the place of residence (See Section 212.000).

The WIC (Women Infants Children) Program must be accessed first for individuals aged 0 to five (5) years.

Nutritional supplementation is not covered under the Hyperalimentation Program.

216.000 Documentation Requirements 10-1-06

The hyperalimentation provider must keep and maintain written records, inclusive of all documentation submitted requesting prior authorization. See section 202.000 for general records that must be included in the provider's files and section 212.000 for records regarding prior authorization.

All Medicaid providers are required to keep and maintain records that fully disclose the type and extent of services provided to an Arkansas Medicaid beneficiary. Providers are reminded that pertinent records concerning the provision of Medicaid covered health care services are to be made available during regular business hours to all Division of Medical Services staff acting within the scope and course of their employment.

Records are also to be made available to the Division's contractual review organization, when applicable.

The hyperalimentation provider must establish and maintain written documentation in each beneficiary's file to support the medical necessity of each provided service. The beneficiary's medical record, maintained by the provider, must include documentation from the beneficiary's hospitalization which supports the medical necessity of the prescribed parenteral or enteral nutrition therapy.

All entries in a beneficiary's file must be signed and dated by the individual providing the service to include the person's full name and credentials.

Other documentation in a beneficiary's file must include:

A. The beneficiary's name and Medicaid identification number

B. The specific service provided

C. The date services are provided

D. Updated progress notes describing the nature and extent of specific services provided

E. All documentation submitted requesting prior authorization from DMS. (See section 212.000 for documentation requirements.)

222.000 Request for Prior Authorization 10-1-06

Requests for prior authorization originate with the provider. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of the Request for Prior Authorization and Prescription Form. **View or print form DMS-2615 and instructions for completion**. This form must be signed and dated by the prescribing physician.

The request for prior authorization will be reviewed by the Arkansas Foundation for Medical Care, Inc., (AFMC). All requests must be submitted by mail. **AFMC will not accept prior authorization requests via FAX.** The documentation submitted with the prior authorization request must support the medical necessity of the requested nutritional therapy. In some cases, AFMC may request additional information (i.e., original prescription, records from the hospitalization initiating nutritional therapy, nutritional assessment to establish medical necessity for nutritional therapy, etc.). **View or print AFMC contact information.**

222.100 Approvals of Prior Authorization Requests 10-1-06

When the PA request is approved, a prior authorization control number will be assigned by AFMC. **View or print AFMC contact information.** Prior authorization approvals are authorized for a maximum of six (6) months (180 days) or for the life of the prescription, whichever is shorter. If the prescribing physician documents the beneficiary's condition is chronic and unlikely to change, a prior approval may be authorized for a maximum of twelve months. The effective date of the prior authorization will be the date the patient will begin therapy or the day following the last day of the previous authorization approval.

222.200 Denial of Prior Authorization Requests 10-1-06

For a denied request, a letter containing case specific rationale that explains why the request was not approved will be mailed to the requesting provider and to the Medicaid beneficiary.

The provider may request reconsideration of the denial within thirty-five calendar days of the denial date. Requests must be made in writing and include additional documentation to substantiate the medical necessity or program criteria of the requested services.

222.300 Reconsideration Requests 10-1-06

If the decision is reversed during the reconsideration review, an approval is forwarded to all relevant parties specifying the approved units and services. If the denial is upheld, the provider and the Medicaid beneficiary are notified in writing of the review determination.

Reconsideration is available only once per prior authorization request. **A subsequent prior authorization request will not be reviewed if it contains the same documentation submitted with the previous authorization and reconsideration requests.**

A pre-approval of hyperalimentation services does not guarantee payment.

222.400 Fair Hearing Requests 10-1-06

The Medicaid beneficiary may request a fair hearing of an adverse review determination from the Department of Health and Human Services (DHHS). The appeal request must be in writing and sent to the Appeals and Hearings Section of DHHS within thirty-five calendar days of the date on the denial letter. Providers may refer to section 190.000 for information regarding provider appeals through the Medicaid Fairness Act.

223.000 Pre-Approval of Hyperalimentation Services 10-1-06

When an eligible Medicaid beneficiary is discharged from the inpatient setting with the continuation of hyperalimentation services in the home, a provider may request a pre-approval for hyperalimentation prior to the anticipated discharge date. The request for pre-approval must be faxed to AFMC. **View or print AFMC contact information.**

When approved, a prior authorization number will be assigned and will be effective for thirty days. The provider must not bill for hyperalimentation services prior to the date of discharge or bill for services on the same dates of service as the inpatient stay.

If the beneficiary is not discharged within the thirty days the pre-approval will be void.

When continuation of the therapy is required past the initial thirty (30) day pre-approval, the provider must submit a recertification for prior authorization request for continuation of the therapy, with a prescription signed by the prescribing physician, prior to the end date of the pre-approval.

A pre-approval of hyperalimentation services does not guarantee payment.

242.142 Equipment and Supplies for Enteral (Sole Source) Nutrition Therapy -1-06

Equipment and supplies necessary for the administration of enteral (sole source) nutrition therapy in the beneficiary's place of residence are included in the unit reimbursement price. Prior authorization is required for the enteral infusion pump and the pump supply kit and may be billed separately. The prior authorization request for the pump must contain supporting documentation to establish medical necessity (e.g., gravity feeding is not satisfactory due to aspiration, diarrhea, dumping syndrome, etc.).

The required type of service code is indicated by the heading TOS. Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Procedure Code	TOS	Description	PA Y/N
B9000	9	Enteral nutrition infusion pump – without alarm	Y
B9002	9	Enteral nutrition infusion pump – with alarm	Y
B4035	9	Enteral feeding supply kit; pump fed, per day	Y

Arkansas Foundation for Medical Care Contact Information:

In-state and Out-of-state Toll Free:	1-877-650-2362
Fort Smith Exchange:	(479) 649- 8501
Fax Number:	(479) 649-0799
Fax for Pre-approvals:	(479) 649-0776
Mailing Address:	Arkansas Foundation for Medical Care, Inc. PO Box 180001 Fort Smith, AR 72918-0001
Physical Site Location:	2201 Brooken Hill Drive Fort Smith, AR 72908
Office Hours.	8:30 a.m. until 5:00 p.m. (Central Time), Monday through Friday, except holidays

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TO: **Arkansas Medicaid Health Care Providers**

DATE: **October 1, 2006**

SUBJECT: **Section V Provider Manual Update Transmittal**

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REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
DMS-2615	8/86	DMS-2615	10/06

Explanation of Updates

The Arkansas Foundation for Medical Care, Inc. (AFMC) will perform prior authorizations for hyperalimentation services. The prior authorization request form DMS-2615, has been renamed and revised. Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789.

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Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

ARKANSAS MEDICAL ASSISTANCE PROGRAM

PRESCRIPTION & PRIOR AUTHORIZATION REQUEST FOR NUTRITION THERAPY & SUPPLIES

SECTION A - TO BE COMPLETED BY PROVIDER

☐ "Pre" Approval (30 days) ☐ Initial ☐ Recertification ☐ Modification	Requested Start Date:
Beneficiary Name: (Last, First, MI)	Beneficiary Medicaid ID #:
Beneficiary Mailing Address:	Date of Birth: / Sex: ☐ Male ☐ Female
Prescribing Physician:	Physician MCD Provider #:
Provider Name: / Medicaid Provider #: / Provider Phone #:	Provider Mailing Address:

PROCEDURE CODE:	MOD 1:	MOD 2:	TOS:	NARRATIVE DESCRIPTION:	UNITS REQUESTED:

I attest that the information contained in this request is accurate to the best of my knowledge.

PROVIDER SIGNATURE _____ DATE _____

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

Est. Length of Need: Weeks Months Perm	EPSDT Referral: ☐ Yes ☐ No ☐ N/A	Date of Last Exam by Prescribing Physician:
Height: In Date Measured:	Weight: Lbs Date Weighed:	
Diagnosis & ICD-9 Code:	Diagnosis & ICD-9 Code:	Diagnosis & ICD-9 Code:

Will the nutrition therapy be used in the beneficiary's home? ☐ YES ☐ NO

Is the prescribed therapy the beneficiary's sole source of nutrition? ☐ YES ☐ NO

If applicable, can the beneficiary progress to enteral nutrition? ☐ YES ☐ NO ☐ N/A

PHYSICIAN PRESCRIPTION FOR ENTERAL NUTRITION

ENTERAL PRODUCT NAME:	CALORIES/DAY:	VOLUME/DAY:

Frequency: ☐ Daily ☐ M-W-F ☐ Other: (Specify)

Method of Administration: ☐ Gravity ☐ Enteral Nutrition Infusion Pump (*Requires documented medical necessity*)

PHYSICIAN PRESCRIPTION FOR PARENTERAL NUTRITION

AMINO ACID:	Ml/day	PROTEIN gm/day	SODIUM:	mEq	POTASSIUM	mEq
LIPIDS:	Ml/day	% Concentration	CALCIUM:	mEq	MAGNESIUM	mEq
DEXTROSE:	Ml/day	% Concentration	OTHER:			

Total Volume Prescribed: Ml/day Frequency: ☐ Daily ☐ M-W-F ☐ Other: (Specify)

Medical Diagnosis(es) and Indication for Nutrition Therapy:

PHYSICIAN SIGNATURE _____ DATE _____

**A prescription for the requested items MUST be documented above or a separate prescription MUST be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required.

DMS-2615 (10/06)

Instructions for completion of the Prescription & Prior Authorization Request for Nutrition Therapy & Supplies (Form DMS-2615)

SECTION A - TO BE COMPLETED BY PROVIDER	
REVIEW TYPE:	Indicate the type of prior authorization request: “Pre” Approval (a 30 day authorization to provide initial set-up of services post-hospitalization), Initial (new requests that do not follow hospitalization), Recertification, or a Modification of a current authorization.
DATE(s) of SERVICE requested:	Enter the requested start date.
PATIENT INFORMATION:	Enter the beneficiary’s full name (Last, First, MI), ten-(10) digit Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PHYSICIAN INFORMATION:	Enter the prescribing physician's name and assigned nine-(9) digit Arkansas Medicaid provider number.
PROVIDER INFORMATION:	Enter the provider name, address, assigned nine-(9) digit Arkansas Medicaid provider number, and telephone number.
PROCEDURE CODES:	List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
PERSON SUBMITTING REQUEST:	The person submitting the request must sign and date, verifying the attestation in this section.
SECTION B - MUST BE COMPLETED BY THE PHYSICIAN	
EST. LENGTH OF NEED:	Enter the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if it is expected that the patient will require the item for the duration of his/her life.
EPSDT REFERRAL:	If applicable, indicate if the request is being made as the result of an EPSDT referral.
DATE LAST EXAMINED:	The prescribing physician must examine the beneficiary within 60 days of the requested start date for initial and recertification requests.
HEIGHT & WEIGHT:	Enter the beneficiary’s current height measured in inches and weight measured in pounds and record the date each measurement was taken.
DIAGNOSIS & ICD-9 CODES:	In the first space, list the diagnosis & ICD9 code that represents the primary reason for ordering this item. List any additional diagnosis & ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	Answer each question by checking the appropriate box or fill in the requested information.
PHYSICIAN PRESCRIPTION:	List the name, calories per day and volume per day for each enteral nutrition product prescribed or list the prescribed parenteral nutrition.
MEDICAL NECESSITY:	The physician must document medical necessity for the requested services and sign/date in the space indicated. Signature and date stamps are NOT acceptable.
**PRESCRIPTION:	A written prescription MUST be submitted with all requests. This can be documented on the request form or a separate prescription may be attached.
**LETTER OF MEDICAL NECESSITY:	If the information provided on the request form is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician may be required.