DEPARTMENT OF ELDER AFFAIRS TECHNICAL ASSISTANCE – Disposable Incontinence Medical Supplies Fee Schedules

September 28, 2012

Please see the attached FAQ list related to the Disposable Incontinence Medical Supplies Fee Schedules.

We have attempted to incorporate all questions/topics that were received; however, please note that due to similar questions being asked across PSAs, it was necessary to streamline the list for clarity and brevity.

We received many questions about the hierarchy of payment, and it warranted a separate mention here.

Q. What is the billing hierarchy for these rules?

A. Funding sources must be accessed in this order:

1. *Third Party Payer*
2. *Medicare*
3. *Medicaid State Plan programs*
4. *Waiver*

It is the responsibility of the waiver services provider, with the assistance of the waiver case manager, to determine whether the same type of service offered through the waiver is also available through other funding sources. No service may be provided under a waiver if it is already provided by another Medicaid program unless the type or the amount of service necessary would not be covered under the other Medicaid program.

To extrapolate on the last two sources, the process is further defined below:

Step 1: Consult the fee schedule titled DME and Medical Supply Services for All Recipients, and if the item is listed, submit the claim for the item.

Step 2: While waiting for approval or denial of the claim, order the item using the code from the "new" fee schedules:

- Assisted Living Waiver Incontinence Fee Schedule and Quality Standards (12/1/11)
- Aged and Disabled Adult Waiver Incontinence Fee Schedule and Quality Standards (12/1/11)

Step 3: If the item is not available on the "new" fee schedules or does not meet the client's requirements, ensure that a prescription is obtained from the waiver recipient's physician and order the item using code in the waiver fee schedules:

- Assisted Living for the Elderly Waiver Services Procedure Codes and Fee Schedule

- Aged and Disabled Adult Waiver Procedure Codes and Fee Schedule

Step 4: If a denial is received from State Plan, the denial is only needed once for the client's record/file, and Steps 2 and 3 may be followed for future purchases of that particular product.

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Topic	Question	Answer
ALW Fee Schedule	The fee schedule sent is for ADA only using modifier U2. Will there be a separate ALW fee schedule? Or will they bill using these codes and a U3 modifier?	Assisted Living has its own fee schedule. Please refer providers to the AHCA's website: http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx
Billing Guidelines	If the CMS providers will be billing, will we be using the existing ADA provider network? Will they need to add ALW to their provider I.D's with a provider maintenance request? Will they also need a referral agreement for ALW?	Only case management agencies and assisted living facility waiver providers can have an AL Waiver provider number to bill for services. Therefore, ALFs are required to bill using the procedure codes for ALF services and incontinence supplies.
Billing Guidelines	The "Billing Guidelines" sent a few weeks ago indicates in the grey areas, "The codes listed below...". However, there are no codes listed below the grey areas. Can you clarify this?	The grey areas in the Billing Guidelines are intended to correspond with the grey areas in the Fee Schedules. Therefore, it was not necessary to list the codes again.
Billing Guidelines	It is understood that T4543 is for all Diapers either 2X, 3X, or bariatric sized. However, the area of confusion is what is the code for 2X, 3X, or bariatric Pullups? Pullups and Diapers are not the same type of incontinence products; however several people are indicating to bill 2X or bariatric pull-ups as briefs (T4543) but this is incorrect and in effect fraud. The providers would need clarification of what code will be used to bill for 2X, 3X, and Bariatric Pull-ups.	AHCA does not have a code listed for the items mentioned in this questions. If you are aware of a code that already exists, please let us know so we can request a code be developed. If there is a question about an appropriate code not available for a particular item, please use the original CMS procedure code: S5199.
Billing Guidelines	It is our understanding that AL Waiver Assisted Living Facilities still can purchase incontinence supplies where they wish to. The facilities can only submit claims using the new procedure codes and will only be reimbursed for the rates/unit costs that are listed on the Assisted Living Waiver Disposable Incontinence Fee Schedule. Is this correct?	There has been no change in where the assisted living facilities contract to procure incontinence supplies. As far as reimbursement, the individual items have maximum rates, but if a client is prescribed supplies by their physician outside the limitation presented in the DME-AL fee schedule, then case managers can authorize the use of the CMS code S5199 with the justification of the requirement by physician in the case narrative/case record.
Billing Guidelines	Since ALFs bill the waiver for Incontinence Supplies purchased from another provider, are they permitted to bill for the supplies purchased during the month or must they track the actual number used by the client during the calendar month and bill for that amount?	Per page 3-4 of the AL Handbook, "This service is billed once a month using the last day of the month for which reimbursement is being requested. The total billing should represent the amount of the number of incontinence supplies used by the waiver consumer."
Billing Guidelines	Currently, MW Specialists review receipts for the purchase of incontinent supplies that are billed for a particular month during the facility monitoring. Under the new system, would the incontinent supplies be coming from the State Plan (Non-DOEA) and therefore, not included in calculating the CP cost to the AL Waiver?	If the supplies are ordered off of the incontinence supplies list that was crafted for the Assisted Living Waiver or the Aged and Disabled Adult Waiver, and the claim includes the waiver modifier, the cost for those supplies is still being deducted from the waivers and must be reviewed.

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Billing Guidelines	If an ALF purchases incontinent supplies from a provider at less than the Max on the Fee Schedule, may they bill at a higher rate or the Max rate to cover their expenses in tracking and maintaining the client's supply of incontinence products?	The rates are listed as maximum rates.
Billing Guidelines	I would like to assume these may be batched for billing at the end of the month, not entered on the day the supplies were used, but one can never assume. Is this correct?	Correct. AHCA has not directed that supplies must be billed daily. Providers may continue billing according to page 3-4 of the AL Handbook, which states, "This service is billed once a month using the last day of the month for which reimbursement is being requested."
Billing Guidelines	Do providers need a specialty enrollment to bill for these supplies under the State Plan?	No.
Billing Guidelines	And are the ALF's then supposed to be trained to bill using this procedure code list even though they are not CMS / DME providers? Or will the DME / CMS providers be billing for these items and ALF's no longer submit those claims?	The assisted living facilities are have been billing for incontinence supplies using CMS S5199 since 1992, the only difference is that now they have to bill using mulitple codes for each item. Having stated that, the codes on the "Aged and Disabled Adult Waiver Incontinence Fee Schedule and Quality Standards (12/1/11)" and the "Assisted Living Waiver Incontinence Fee Schedule and Quality Standards (12/1/11)" may be billed by the waiver provider; however, please refer to the instructions in the gray boxes at the top of each section, as some restrictions apply to recipients aged 21+.
Billing Guidelines	From AL MW case managers: On the DME log the max payment amount of reimbursement is listed for example for diapers $.63 each. If the facility is using a provider that is charging more than the $.63, do we recommend them changing providers or are they supposed to eat the cost?	Providers must abide by the maximum costs listed on the fee schedules when contracting with their incontinence providers. If supplies do not meet the standard prescribed by the client's doctor's presciption, then they could be billed using the code S5199 per each waiver's limitations in the fee schedules and handbooks.
Billing Guidelines	Do the codes have to be billed daily (as the ALW procedure code has to be billed now), or can it be billed once per month? If so, does this apply to the ADA - MW providers, as well?	The codes do not have to be billed daily. Per page 3-4 of the AL Handbook, "This service is billed once a month using the last day of the month for which reimbursement is being requested."
Billing Limits	What exactly does it mean "see waiver for policy rules and limits"? Where can this information be found?	Please refer to the Aged and Disabled Adult Waiver Procedure Codes and Fee Schedule and the ADA Handbook OR the Assisted Living for the Elderly Waiver Services Procedure Codes and Fee Schedule and the AL Handbook for limitations.

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Billing Limits	Based on the new fee schedules, several items have limits now which will affect many of the clients currently receiving incontinence supplies because they receive a higher amount per month. For example, the ADA incontinence fee schedule indicates that only 150 underpads may be billed per month. However, we have clients that currently receive more than that amount. Based on this, their services would be reduced which may cause an unmet need. It seems that the limits are set on the fee schedule and the clients in these situations would not be able to get an additional amount. As a result, if a client would like to go through a grievance and/or fair hearing, would they be able to do this?	This situation would be defined as a product on the "new" fee schedule not being able to meet a client's need. As such, the client would need a doctor's prescription for a more products, and then they could be billed using the code S5199 per each waiver's limitations in the fee schedules and handbooks. Per the ADA and AL Handbooks, clients may submit grievances and/or fair hearings.
Billing Limits	If the supplies are being provided through State Plan, will the provider still be limited to a TOTAL of $125.00 per month for Incontinence Supplies?	Per the FAQ for the Disposable Incontinence Medical Supplies Fee Schedules: Q: On the Waiver Disposable Incontinence Medical Supplies Procedure Codes and Fee Schedule certain items must be billed under state plan. After the Medicaid State Plan limits are exhausted, can the waiver programs be billed? A: Once the Medicaid State Plan limits are exhausted, waiver programs can be billed up to the waiver fee schedule limit...
Billing Limits	ADA: If the supplies are being provided through State Plan, will the provider still be limited to a TOTAL of $500.00 per month for Incontinence Supplies and other consumable medical supplies?	Per the FAQ for the Disposable Incontinence Medical Supplies Fee Schedules: Q: On the Waiver Disposable Incontinence Medical Supplies Procedure Codes and Fee Schedule certain items must be billed under state plan. After the Medicaid State Plan limits are exhausted, can the waiver programs be billed? A: Once the Medicaid State Plan limits are exhausted, waiver programs can be billed up to the waiver fee schedule limit...
Care Plans	AL: Would care plans have to specify the exact products or leave that to the discretion of the provider and the client?	Care Plans must begin specifying the exact products. An attachment may be necessary.
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Care Plans	From AL MW case managers: Do you want the DME billing codes on the care plan?	No. The care plan should list the specific items. The service authorization will need to note the fee schedules from which the products should be ordered.

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Care Plans	From AL MW case managers: Do we have to do a separate care plan page for each billing code (example diapers, wipes and bed pads)? And can you provide us with an example?	Care Plans must begin specifying the exact products. An attachment may be necessary. Each case management agency will need to create a format of their preference that communicates the information in a clear, organized manner to facilitate review by the client as well as any reviews/audits.
Claims Entry	Some providers have advised that diaper claims are not being processed by FLMMIS? What is the proper method for a provider to bill for diapers?	For **diapers only**, AHCA advises that the provider must use the referring physician's Medicaid ID in the billing.
Client's needs not met by DME Fee Schedule	Under FAQ #4, the information refers to the minimum quality standards. As per the providers, it is understood that all incontinence items given must meet the minimum quality standards. However, there is a discrepancy between what meets the quality standards and what can financially be given to the clients. The providers have indicated that they will provide products that meet the medical needs of the beneficiary; however, they have also indicated that they should not be expected to provide items that would be a financial loss.	If the product that the client receives does not meet the quality standards, they would need a prescription from the doctor authorizing that particular product to be used. The products can be then be purchased through the waiver using the code S1599 per each waiver's limitations in the fee schedules.
Client's needs not met by DME Fee Schedule	Providers have continued to indicate that the current fee schedule T codes do not offer different tiers for the absorbency of products. Under the current reimbursement rates, they've said that standard absorbency and plus absorbency products can be offered, but the rates are too low and heavy/overnight/maximum absorbency products can DEFINITLEY not be given under the rates. The reimbursement for the T codes are not enough for Providers to cover the cost of a heavy and/or maximum absorbency product. Therefore many severely incontinent patients will suffer greatly by receiving less absorbent products.	This situation would be defined as a product on the "new" fee schedule not being able to meet a client's need. As such, the client would need a doctor's prescription for a more absorbent product and then it could be billed using the code S1599 per each waiver's limitations in the fee schedules.
Client's needs not met by DME Fee Schedule	From AL MW direct service providers: Who approves billing for items which don't fit into the waiver fee schedule or are available under state plan. What does it mean when you say the following: Approval of items requested under S5199 is at the waiver's discretion...?	This situation would be defined as a product on the "new" fee schedule not being able to meet a client's need. As such, the client would need a doctor's prescription for the needed product(s) and then the product(s) could be billed using the code S1599 per each waiver's limitations in the fee schedules.
Code A4335	Under the Fee schedule the code A4335 is for "Miscellaneous Incontinence Supply" with a max. rate of $19.40 per month. What products can be given for this code?	Per Carol Schultz (AHCA): "This would be like the S5199 procedure code we use for consumable medical supplies. I would not worry about using this code but continue using the S5199 U2 or TS U2."

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Code implementation	We received the information regarding the implementation of the new procedure codes for the incontinence supplies. "It should coincide with plan of care renewals. If a recipient has to update their plan of care, say tomorrow, then they should use the new codes. If next month then etc… As I understand the information: • The new codes should be used when a current care plan is updated/revised. • The new codes should be used when a care plan is renewed (a new one is prepared) at re-assessment time. Is this correct?	Yes
Code implementation	What is the official date by which all providers should be billing with the new codes? If the CM's start doing this based on the quarterly care plan reviews (as indicated by Dan's email), it would 1 year for all clients to fall into this. Therefore, it seems that the providers would start billing like this now (as the CM's begin authorizing the supplies as per the new fee schedule), and by January 2013, all clients would be receiving the supplies accordingly and all providers would be billing using this new schedule. Based on this, it would seem that the full implementation date would be January 2013.	• The new codes should be used when a current care plan is updated/revised. • The new codes should be used when a care plan is renewed (a new one is prepared) at re-assessment time.
Code S5199	Clarification is needed as to what specific products can be provided under the code "S5199". Based on the FAQ Sheet, "The S5199 code can be used to bill consumable medical supplies that are not otherwise coded in the waiver fee schedule or available under the state plan. Approval of items requested under S5199 is at the waiver's discretion." These items include wipes, baby powder, perineal cleaner and other supplies. However, can you give us a specific description of items which can be ordered under this procedure codes so that the providers are aware.	There is no list that notes specific items that may be ordered under procedure code S5199. Please refer to the Aged and Disabled Adult Waiver Procedure Codes and Fee Schedule and the ADA Handbook OR the Assisted Living for the Elderly Waiver Services Procedure Codes and Fee Schedule and the AL Handbook for limitations.
Code S5199	How much can be invoiced/billed under "S5199" per month?	The process to bill with this procedure code and any other procedure code has not changed. Please refer to the Aged and Disabled Adult Waiver Procedure Codes and Fee Schedule and the ADA Handbook OR the Assisted Living for the Elderly Waiver Services Procedure Codes and Fee Schedule and the AL Handbook for limitations.

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Code S5199	What exactly does "by invoice" mean for code S5199?	The process to bill with this procedure code and any other procedure code has not changed. Please refer to the Aged and Disabled Adult Waiver Procedure Codes and Fee Schedule and the ADA Handbook OR the Assisted Living for the Elderly Waiver Services Procedure Codes and Fee Schedule and the AL Handbook for limitations.
Code S5199	Do the units billed as "S5199" fall under the max of a total 200 units? If not, what is the max total units for S5199?	The units/maximum to bill with this procedure code and any other procedure code have not changed. Please refer to the Aged and Disabled Adult Waiver Procedure Codes and Fee Schedule and the ADA Handbook OR the Assisted Living for the Elderly Waiver Services Procedure Codes and Fee Schedule and the AL Handbook for limitations.
Code S5199	From ADA MW direct service providers: May we continue to bill using procedure code S5199 until the new care plan authorizations are completed by case managers? Or, should billing for incontinence supplies be postponed until all care plans are properly updated?	Yes, please continue to use code S5199 until the care plan is updated.

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Code T4543	From AL MW direct service providers: T4543 U3 - can we use this code for Poise Pads?	Code item T45**43** (DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, BARIATRIC, EACH) is listed under the section that states, "The codes listed below are billable under the Durable Medical Equipment (DME) and Medical Supplies State Plan Program for recipients 4 to 20 years of age. For recipients under age 21, providers must bill the DME State Plan Program up to the maximum limit before billing the waiver for these codes. Reimbursement for these codes under the waiver is counted towards the total allowable reimbursement for medical supplies established under the waiver." Per the Billing Guidelines for the Disposable Incontinence Medical Supplies Fee Schedule, the clarifications for the instructions in the gray section state the following: "For recipients OVER the age of 21, enrolled waiver providers/support coordinators can access the appropriate waiver program directly." The case manager may wish to research whether code T45**35** (DISPOSABLE LINER/SHIELD/GUARD/PAD/ UNDERGARMENT, FOR INCONTINENCE, EACH) more appropriately aligns with the product description and purpose.
Columns in Fee Schedules	The fee schedules have a column titled, “Yearly Total.” What constitutes a year?	A year from the date of initial purchase/claim submission. Per AHCA, the information in that column is from multiplying cost of the supplies by the units allowed.
Hierarchy of payment	If the ALF is going to be billing for the CMS supplies using the new codes how will they be able to ensure that the hierarchy of payment is followed since they are not Medicaid state plan providers?	Case manager is responsible for the activity of ensuring all other resources whether state plan, Medicare, or private pay are utilized prior accessing waiver services. The codes will need to be communicated by the case manager to the provider in the service authorization.
iBudget	What exactly are the new billing rules? One of the providers brought up "iBudget". Does this have to do with the new billing rules for the incontinence supplies. If so, can you let us know what it is, exactly? When will that be implemented? And when and where will training be provided? The providers are asking that sufficient time be given for everyone to successfully transition billing to this new system.	iBudget is a system maintained by the Agency for Persons with Disabilities for the Developmental Disabilities waiver. Providers may reference the following link for more information: http://apd.myflorida.com/ibudget/.

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Topic	Question	Answer
Immediate Needs	We have received a couple of requests for additional incontinence supplies and the requests are of immediate nature. Skin integrity may be an issue. • Does the client have to wait until the case manager discusses the program changes/care plan changes with the client? • Are there any exceptions for immediate need until the case manager meets with the client?	No. Please instruct case managers to serve the immediate needs of the client until a care plan review can be performed.
State Plan Denials	As of the update for the additional needs, would the provider be required to have a denial from Medicaid State Plan prior to providing the products?	For products listed on the"DME and Medical Supply Services for All Recipients" fee schedule and either the "Aged and Disabled Adult Waiver Incontinence Fee Schedule and Quality Standards (12/1/11)" or the "Assisted Living Waiver Incontinence Fee Schedule and Quality Standards (12/1/11)", the provider is required to follow the directions at the top of each set of codes. If the directions at the top of the set of codes state that providers must bill the DME State Plan Program up to the maximum limit before billing the waiver for the particular set of codes, then the provider must enter the claim accordingly. Please also reference the Billing Guidelines for the Disposable Incontinence Medical Supplies Fee Schedule. While the claim/denial is transpiring, the provider can supply the needed products to the client and bill the waiver per the "per item" limits established in the overall limits imposed by either the "Aged and Disabled Adult Waiver Procedure Codes and Fee Schedule" or the "Assisted Living for the Elderly Waiver Services Procedure Codes and Fee Schedule."
State Plan Denials	How long does it take to receive a denial through State Plan? If families have to cover incontinence supplies while waiting for the denial, it is a financial burden on the families.	The time frame is unknown, but you may contact your local Medicaid office for a better estimate. While that claim/denial is transpiring, the provider can supply the needed products to the client and bill the waiver per the "per item" limits established in the overall limits imposed by either the "Aged and Disabled Adult Waiver Procedure Codes and Fee Schedule" or the "Assisted Living for the Elderly Waiver Services Procedure Codes and Fee Schedule."

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State Plan Denials	If State Plan will not pay for incontinence supplies, why go through the process of receiving a denial?	Only submit for those items listed on the DME schedules. Otherwise, the other codes on the specific waiver fee schedules are meant for waiver only.
State Plan Denials	Agencies have to go through State Plan providers to receive State Plan denials. There is concern that these providers will not supply the denials. What should be done?	Please provide examples to DOEA when this occurs and the Agency for Health Care Administration will be notified.
State Plan Denials	How often do State Plan denials need to be obtained?	Providers only need to seek a denial once for each different product listed on the care plan that are also listed on the approved items on the DME Fee Schedules (For All Recipients or Over 21 years old).
State Plan Denials	Why do case managers need a denial for incontinent supplies when the DME and Medical Supply Coverage and Limitations Handbook states on page 2-97 listing non-covered items “Diapers and incontinent briefs of any kind for recipients 21 years and older.”	Denials are only needed for those items already listed on the state plan DME fee schedules(For All Recipients or Over 21 years old).
State Plan Denials	Is denial documentation from a state plan Medicaid provider required for incontinent supplies prior to using waiver funds?	Denials will be needed from state plan Medicaid only for those items listed in the DME fee schedule for over the age of 21 or when it states "all recipients".
Tracking on service logs	Is there a specific way that you would like the ALW providers to track these supplies on the ALW service logs, since each supply will be billed individually from now on?	Each ALW provider must determine their preferred methodology for tracking supplies on the supply logs; however, the logs must clearly note the supplies for monitoring purposes.
Tracking on service logs	Will the facilities still have to track the amount of INCS used per resident?	Per page 3-4 of the AL Handbook, "...AL providers must keep accurate monthly records of supplies used by individual waiver consumers."
Tracking on service logs	From AL MW case managers: At the facilities, do they have to put a daily usage amount on the CMS log? If so, do we have to count the number used and that is what goes on the care plan, or can we still do an estimate example 1 to 2 cases per month with maximum units of 200?	The methodology for recording the usage of the CMS supplies is at the ALF's discretion, as long as the tracking and billing is conducted in accordance with page 3-4 of the AL Handbook: "This service is billed once a month using the last day of the month for which reimbursement is being requested. The total billing should represent the amount of the number of incontinence supplies used by the waiver consumer. Individual waiver incontinence supplies must be maintained in a separate location and AL providers must keep accurate monthly records of supplies used by individual waiver consumers. However, if the recipient is admitted to a hospital or a nursing facility, the date of service (DOS) must be the day before the recipient’s admission in order for incontinence supplies to be reimbursed."