The Secretary for Health Services
COMMONWEALTH OF KENTUCKY
275 EAST MAIN STREET
FRANKFORT 40621-0001
(502) 564-7042

PAUL E. PATTON
GOVERNOR

MARCIA R. MORGAN
SECRETARY

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Dear Prescriber:

This letter is to update you on the changes to policy affecting coverage and payment methodology for the Durable Medical Equipment (DME) Program.

The Kentucky Medicaid program is being examined from top to bottom to find areas where utilization can be better managed. In examining the DME program, it became apparent that the increased threshold for prior authorization for DME expenditures, from $150.00 to $300.00, has resulted in significant increased expenditures. The need for other improvements in billing and PA protocols also became apparent.

Therefore, due to budget constraints and the need for improved program management, the Department will make the following changes effective January 2, 2003:

- The required Certificate of Medical Necessity (CMN) shall be the approved Medicare CMN in use at the time the DME item was prescribed by a physician, podiatrist, optometrist, dentist, advanced registered nurse practitioner, or physician's assistant. If there is no Medicare CMN, the approved Medicaid CMN, MAP-1000, shall be used. The DME provider must subsequently receive for and retain in their files the signed hard copy original CMN from the prescriber.

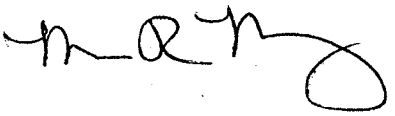
- Date of service shall be the date the item is delivered to the recipient's home. In the case of mail order DMEPOS the date of service is the latter of the date of shipping or the date of discharge to a recipient's home from an inpatient hospital or nursing facility. DMEPOS delivered to a recipient's home immediately following a hospital inpatient or nursing facilities stay, the date of service shall be the date of final discharge. It may be appropriate for DMEPOS to be delivered up to two (2) days prior to discharge from a facility for the benefit of fitting or training of the patient and/or care provider(s). However, the equipment must be for use in the recipient's home and no billing shall be done prior to the date of the recipient's discharge from the facility.

- Prior authorization shall be required for the following: an item or repair billed to the Department at **$150.00** or more; any item denoted by a miscellaneous code; an item exceeding the limitations set in the Medicaid DME Program Fee Schedule; and any **new** code that is not on the Medicaid DME Program Fee Schedule but is determined by the Department to be a covered benefit.

- Prior authorization shall be submitted by the DME provider to Kentucky Medicaid Peer Review contractor **prior to but no later than seven (7) business days from the date of service. It is essential that the CMN is signed and returned to the DME provider quickly.**

These changes are being promulgated to ensure accurate, efficient processing of claims and prior authorizations as well as closer oversight of the program. If you have any questions regarding policy, please contact Charles Douglass, Branch Manager in the Specialty Services Branch at 502-564-2687. For information regarding billing, contact the Kentucky Medicaid Management Information Systems contractor's provider relations 1-800-807-1232. For information regarding prior authorization, contact Kentucky Medicaid's Peer Review contractor at 1-800-292-2392.

Sincerely,



Marcia R. Morgan
Secretary

MRM/LCB/sm

CC: Mike Robinson