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# WISCONSIN MEDICAID UPDATE

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July 16, 1996

UPDATE 96-26

TO:  
DME Vendors  
Home Health Agencies  
Pharmacies

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**Billing for Enteral Nutrition Products - Effective**  
with dates of service on and after August 1, 1996

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## **New coding structure begins August 1, 1996**

Effective for dates of service on and after August 1, 1996, providers must use HCPCS procedure codes for enteral nutrition products. Currently, these products are billed using national drug codes (NDC). This change allows Wisconsin Medicaid to use the same codes and pricing structure as Medicare. Prior authorization (PA) continues to be required for all enteral nutrition products.

See Attachment 1 for a list of HCPCS codes to use, their corresponding products, and the Medicaid maximum allowable fee per unit for each code.

Medicaid procedure codes for enteral nutrition products may now be updated when national HCPCS codes change.

## **Coverage guidelines remain the same**

Attachment 2 states the Medicaid guidelines for determining if an enteral nutrition product is considered medically necessary. Regular grocery products which can be mixed in a blender are considered food rather than a food supplement and are not covered.

## **Prior authorization (PA)**

### **PA requests received after July 31, 1996, must include HCPCS codes**

You must use the HCPCS code for the requested enteral nutrition product on all prior authorization requests received by EDS after July 31, 1996. This includes new and renewal PAs. The product name determines the appropriate code to request in Attachment 1.

Effective for dates of service on and after August 1, 1996, you may no longer submit PAs for enteral nutrition products using NDC procedure codes.

### **Current PAs may be valid through October 31, 1996**

From August 1 through October 31, 1996, you may continue using already approved PAs with NDCs for billing. You must always bill the procedure code used on the approved PA.

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If you have an approved PA for an enteral nutrition product which expires *after* October 31, 1996, you *must* submit a new PA request using a HCPCS code, before October 31, 1996. On November 1, 1996, all PAs that are approved with an NDC number rather than a HCPCS code will automatically expire.

If you have PAs that need to be changed, please submit them as soon as possible, but at least before October 31, 1996.

### **Determining the quantity to request on your PA**

When completing a PA request for an enteral nutrition product, you must include the number of units you wish to dispense. Wisconsin Medicaid limits providers to a maximum amount of product they may request for prior authorization. The maximum amount is the prescribed amount. Calculations are needed to determine how many units of a product a recipient needs.

To make this calculation easier, Attachment 1 contains the number of units per container for each product. One unit is defined as 100 calories. An example of how to compute quantity is:

- ✓ The physician writes an order for Ensure, 1 can (8 oz.) T.I.D., which means one can three times a day.
- ✓ A 30 day supply requires 90 cans (3 x 30 = 90).
- ✓ Total units for 30 days is 229 [ 90 cans x 2.54 units/can (This number is found in Attachment 1) = 228.6]. This is rounded to 229 units.

Assuming this PA request is granted, the quantity allowed per 30 days is 229 units. Attachments 3 and 4 are completed samples of the prior authorization request form (PA/RF) and the prior authorization drug/DMS attachment (PA/DGA).

### **Updating for new codes**

As new enteral nutrition products come on the market, Medicare assigns them a HCPCS code. You may obtain these codes by calling Sandmerc at (803) 736-6809. If no code is available from Sandmerc, request PA using procedure code W8300.

### **Billing information**

#### **Use the HCFA 1500 when billing HCPCS codes starting August 1, 1996**

Effective August 1, 1996, you must use the HCFA 1500 claim form for billing enteral nutrition products which are approved with a HCPCS code. Bill the HCPCS codes with type of service 9 on the HCFA 1500 once you have an approved PA for enteral nutrition products using HCPCS codes. Be sure to include the approved PA number on your claim.

The HCFA 1500 is the form you currently use to bill disposable medical supplies (DMS) and/or durable medical equipment (DME). You can bill electronically or on paper. Attachment 5 is a completed sample of the HCFA 1500 form.

#### **Medicare must be billed first for recipients dually eligible for Wisconsin Medicaid and Medicare**

When a Medicaid recipient is also eligible for Medicare, you must bill Medicare first for enteral nutrition products *and* be denied payment before billing Wisconsin Medicaid.

#### **What's new...**

Wisconsin Medicaid is in the Department of Health and Family Services (DHFS) formerly known as the Department of Health and Social Services.

If you happen to be out "surfing" the Internet and feel like visiting the DHFS Web site, you can find it at this address:

<http://www.dhfs.state.wi.us/>

**Attachment 1**

**Enteral Nutrition Products Billing Codes  
Effective August 1, 1996**

<b>HCPCS Code</b>	<b>Product Name</b>	<b>Units/Container (100CAL/UNIT)</b>	<b>BHCF MAC/Unit (100CAL)</b>
B4150	Attain	2.50	0.85
B4150	Choice DM	2.52	0.85
B4150	Ensure	2.54	0.85
B4150	Ensure/Fiber	2.64	0.85
B4150	Ensure High Protein	2.28	0.85
B4150	Ensure Light	2.02	0.85
B4150	Fibersource	3.00	0.85
B4150	Fibersource HN	3.00	0.85
B4150	Forta Drink Pdr (gm)	5.52	0.85
B4150	Forta Shake Pdr (gm)	3.01	0.85
B4150	Glytrol	2.50	0.85
B4150	Isocal	2.54	0.85
B4150	Isosource	3.00	0.85
B4150	Isosource HN	3.00	0.85
B4150	Jevity	2.54	0.85
B4150	Kindercal	2.52	0.85
B4150	Meritine Pdr (gm)	19.20	0.85
B4150	Nubasics	2.50	0.85
B4150	Nubasics VHP	2.50	0.85
B4150	Nubasics/fiber	2.50	0.85
B4150	Nutren 1.0	2.50	0.85
B4150	Nutren 1.0/fiber	2.50	0.85
B4150	Nutrin VHP	2.50	0.85
B4150	Osmolite	2.54	0.85
B4150	Osmolite HN	2.54	0.85
B4150	Pediasure Inf Food	2.40	0.85
B4150	Peptamin Jr	2.50	0.85
B4150	Preattain	1.25	0.85
B4150	Probalance	3.00	0.85
B4150	Profiber	2.50	0.85
B4150	Promote	2.40	0.85

HCPSC Code	Product Name	Units/Container (100CAL/UNIT)	BHCF MAC/Unit (100CAL)
B4150	Promote/Fiber	2.40	0.85
B4150	Resource	2.54	0.85
B4150	Resource Diab	2.49	0.85
B4150	Resource Fruit Bevрге	1.82	0.85
B4150	Sustacal liq	2.40	0.85
B4150	Sustacal Pdr (gm)	15.21	0.85
B4151	Compleat	2.65	1.64
B4151	Vitaneed	2.50	1.64
B4152	Comply	3.75	0.70
B4152	Enrich Plus	3.60	0.70
B4152	Ensure Plus	3.60	0.70
B4152	Ensure Plus HN	3.60	0.70
B4152	Isosource 1.5	3.75	0.70
B4152	Liq Nutr Plus	3.60	0.70
B4152	Magnacal	5.00	0.70
B4152	Nubasics Plus	3.75	0.70
B4152	Nutrin 1.5	3.75	0.70
B4152	Nutrin 2	5.00	0.70
B4152	Renalcal liq	5.00	0.70
B4152	Resource Plus	3.60	0.70
B4152	Respalor	3.60	0.70
B4152	Scandishake Pdr (gm)	19.98	0.70
B4152	Sustacal Plus	3.60	0.70
B4152	Twocal HN	4.80	0.70
xx033	Glucerna	2.40	1.60
xx039	Nepro Ready to use	4.80	1.00
xx044	Peptamin	2.50	4.50
xx046	Pregestimil Pdr (gm)	24.00	1.30
xx049	Pulmocare	3.55	0.85
xx051	Suplena RTU	4.80	0.77
xx058	Vivonex TEN Pkt (gm)	3.00	2.83
xx064	MCT Oil	74.21	1.03
xx065	Microlipid	5.40	0.94
xx068	Polycose Liquid	2.50	1.13
xx068	Polycose Pdr (gm)	14.00	0.66
xx073	Advera	3.07	0.75

**Attachment 2**  
**Food Supplement Prior Authorization Guidelines**

<b>Authority</b>	HSS 107.10 (2)(D), Wis. Admin. Code, which states that prior authorization is required for: "all food supplement or replacement products."
<b>Use</b>	Medically necessary, specially formulated enteral nutrition products are used for the treatment of health conditions such as pathology of the gastrointestinal tract or metabolic disorders.
<b>Accepted Indications</b>	<ul style="list-style-type: none"> <li>◆ nasogastric or gastrostomy tube feeding;</li> <li>◆ malabsorption diagnoses including:             <ul style="list-style-type: none"> <li>● Short Bowel (Gut) Syndrome;</li> <li>● Crohn's Disease; and</li> <li>● Pancreatic Insufficiency.</li> </ul> </li> <li>◆ metabolic disorders including cystic fibrosis;</li> <li>◆ limited volumetric tolerance requiring a concentrated source of nutrition (i.e., athetoid cerebral palsy with high metabolic rate);</li> <li>◆ severe swallowing and eating disorders where consistency and nutritional requirements can be met only using commercial nutritional supplements, including (<i>refer below to noncovered swallowing and eating disorders</i>):             <ul style="list-style-type: none"> <li>● dysphagia due to excoriation of oral-pharyngeal mucosa; or</li> <li>● mechanical swallowing dysfunction secondary to a disease process such as:                 <ul style="list-style-type: none"> <li>● cancer or herpetic stomatitis;</li> <li>● oral-pharyngeal trauma such as burns; or</li> <li>● other oral-pharyngeal tissue injury.</li> </ul> </li> </ul> </li> <li>◆ weight loss, with documentation providing the following information:             <ul style="list-style-type: none"> <li>● normal weight, percentile weight, and number of pounds lost in a specified time period;</li> <li>● a specific medical problem which has caused the weight loss; and</li> <li>● specific reasons why a diet of normal or pureed food cannot suffice; and</li> </ul> </li> <li>◆ failure to thrive in infants, with documentation providing the following information:             <ul style="list-style-type: none"> <li>● weight and height, percentile weight and height, and number of pounds lost, if any, in a specified time period;</li> <li>● a specific medical problem or condition which has caused the failure to thrive; and</li> <li>● specific reasons why a diet of formula, normal or pureed food cannot suffice.</li> </ul> </li> </ul>
<b>Noncovered</b>	<p>Prior authorization is not granted for:</p> <ul style="list-style-type: none"> <li>◆ food supplements utilized in nursing homes that are included in the daily rate; and</li> <li>◆ products which can be purchased in a grocery store, drug store, or other retail outlet, with food stamps or with Women, Infant, and Children (WIC) stamps. Individuals who receive food stamps or WIC assistance may be able to use these for the purchase of food.</li> </ul> <p>Noncovered swallowing and eating disorders include:</p> <ul style="list-style-type: none"> <li>◆ swallowing disorders which may lead to aspiration;</li> <li>◆ swallowing disorders which are psychosomatic in nature, as in anorexia or dementia;</li> <li>◆ reduced appetite due to side effects of drug products, as with methylphenidate, amphetamines, appetite suppressants, etc.; and</li> <li>◆ mastication problems due to dentition problems (i.e., lack of teeth).</li> </ul>

POH 1517

## Attachment 3 Sample Prior Authorization Request Form (PA/RF)

MAIL TO:  
E.D.S. FEDERAL CORPORATION  
PRIOR AUTHORIZATION UNIT  
6406 BRIDGE ROAD  
SUITE 88  
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

1 PROCESSING TYPE

637

ICN #  
A.T. #  
P.A. # 1234567

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890		4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) 609 Willow Str. Anytown, WI 55555	
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A.		8 BILLING PROVIDER TELEPHONE NUMBER (XXX ) XXX-XXXX	
5 DATE OF BIRTH MM/DD/YY	6 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	9 BILLING PROVIDER NO. 87654321	
7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE I.M. Billing I.W. Williams Anytown, WI 55555		10 DX: PRIMARY 714.0 Rheumatoid Arthritis	
		11 DX: SECONDARY 531.4 Chronic Gastric Ulcer	
		12 START DATE OF SOI	13 FIRST DATE RX.

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 OR	20 CHARGES
B4150		0	9	Ensure (per 30 days)	229	XX.XX
					TOTAL CHARGE	21 XX.XX

22 An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY DATE      24 J. M. Requesting REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION: <input type="checkbox"/> APPROVED <input type="checkbox"/> MODIFIED — REASON: <input type="checkbox"/> DENIED — REASON: <input type="checkbox"/> RETURN — REASON:	<input style="width: 100%;" type="text"/> GRANT DATE	<input style="width: 100%;" type="text"/> EXPIRATION DATE	PROCEDURE(S) AUTHORIZED      QUANTITY AUTHORIZED
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DATE      CONSULTANT/ANALYST SIGNATURE

Attachment 4

Mail completed forms to:

EDS  
Attn: Prior Authorization Unit - Suite 88  
6406 Bridge Road  
Madison, WI 53784-0088

**PA/DGA**  
**Prior Authorization**  
**Drug/DMS**  
**Attachment**

1. Complete the PA/DGA
2. Attach to the Prior Authorization Request Form (PA/RF)
3. Mail to EDS

Recipient Information

①	②	③	④	⑤
Recipient	lm	A.	1234567890	XX
Last Name	First Name	M.I.	Identification Number	Age

**Section A - Type of Request**

Indicate start date requested/date prescription filled (required) MMDDYY

(check one)

- This is an initial prior authorization request for this drug, for this recipient, by this provider.
- This is a request to renew or extend previously prior authorized therapy using this drug.  
First PA # \_\_\_\_\_
- This is a request to change or add a new NDC number to a current valid prior authorization.  
PA # \_\_\_\_\_ NDC # to add \_\_\_\_\_
- This is a request for a nutritional supplement.

**Section B - Prescription Information** (complete Section B or attach a copy of the prescription order)

Drug Name Ensure Strength \_\_\_\_\_

Quantity Ordered 30 cans per month Date order issued MMDDYY

Directions for use 1 can T. I. D.

Daily Dose 3 cans Refills \_\_\_\_\_

Prescriber Name I. M. Doctor DEA Number \_\_\_\_\_

"Brand Medically Necessary" is hand written by the prescriber on the prescription order:  Yes  No

**Section C - Clinical Information**

List the recipient's condition the prescribed drug is intended to treat. Include ICD-9-CM diagnosis codes for pharmaceutical care recipients. Include the expected length of need.

If requesting a renewal or continuation of a previous prior authorization approval, indicate any changes to the clinical condition, progress, or known results to-date.

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Attach another sheet if additional room is needed.

(Over)

Source for Clinical Information (check one)

- This information was primarily obtained from the prescriber or prescription order.
- This information was primarily obtained from the recipient.
- This information was primarily obtained from some other source (specify): \_\_\_\_\_

Use (check one)

- Compendial standards, such as the USP-DI or drug package insert, lists the intended use identified above as an accepted indication.
- Compendial standards, such as the USP-DI, lists the intended use identified above as a [bracketed] accepted indication.
- Compendial standards, such as the USP-DI or drug package insert, lists the intended use identified above as an unaccepted use.
- The intended use identified above is *not* listed in compendial standards. Peer reviewed clinical literature is attached or referenced. (Reference - include publication name, date, and page number.) \_\_\_\_\_

Dose (check one)

- The daily dose is within compendial standards general prescribing or dosing limits for the indicated use.
- The daily dose is *not* within compendial standards general prescribing or dosing limits for the intended use. Attach or reference peer reviewed literature which indicates this dose is appropriate, or document the medical necessity of this dosing difference. (Reference - include publication name, date, and page number.)

Section D - Complete this Section only if Requesting Enteral Nutritional Supplements

Height XX Percentile (children only) XX  
 Weight XX Percentile (children only) XX

Amount of weight loss, if any, and within what specific time span XX within the last X months  
 (check all that apply)

- This recipient is tube-fed.
- If not tube-fed, number of Kcal prescribed per day \_\_\_\_\_. Percent total calories from this supplement \_\_\_\_\_%.
- This recipient can consume most normal table foods.
- This recipient can consume softened, mashed, pureed, or blenderized food.
- This recipient has a clinical condition, as indicated in Section C, which prevents him/her from consuming normal table, and softened, mashed, pureed, or blenderized foods.
- Comprehensive documentation of this recipient's condition is presented above in Section C - Clinical Information.
- This recipient is eligible for food stamps.
- This product or a similar product can be obtained from WIC.

Signature Im A. Provider R. Ph. Date MMDDYY

Check the appropriate box:

Please notify me of approval/denial by  Fax # \_\_\_\_\_  Telephone # \_\_\_\_\_  No notice needed

**The pharmacist/dispenser must review information and sign and date this form!**



