BILLING INSTRUCTIONS FOR DISPOSABLE MEDICAL SUPPLIES (DMS)/ DURABLE MEDICAL EQUIPMENT (DME) PROVIDERS PEN PROGRAM

Submission for UCA Review	1. Utilization review will be conducted following the start of services and after claim submission. Please retain a copy of all relevant documents in order to submit them for review by the utilization control agent (UCA). 2. The participant's prescription must accompany this **Parenteral and Enteral Nutrition (PEN) Authorization Form** for medical review. 3. Bill the Healthcare Common Procedure Coding System (HCPCS) of the nutritional product dispensed. Question #5 contains spaces for 2 HCPCS, but if additional HCPCS or more details are necessary, use the free-text field provided. a. Bill the **exact HCPCS units as described on the Maryland Medicaid DMS/DME Approved List**. b. Although some enteral items are considered over-the-counter products, the Program still requires a valid prescription for the products to be dispensed. Such prescriptions should be retained a minimum of 6 years and ready for audit. 4. After beginning to provide the PEN services and after submitting direct bill claims, the provider will upload a copy of the revised PEN Authorization Form and prescription to the UCA's provider portal, Qualitrac, along with the corresponding invoice control number (ICN), and any other relevant documentation. After the PEN Form has been submitted, the provider will be notified electronically regarding any status changes or information requests by the UCA. If the participant's/provider's request should be denied, the request may be reconsidered within 30 days, otherwise the denial becomes final and subject to payment recovery.
Certification Type/Date:	The PEN Authorization Form is to certify the full span of the prescription up to a maximum of 1 year. If this is an initial certification for this participant, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the participant's changing clinical needs), indicate the revision date in the space marked "REVISED." If this is a recertification, indicate the recertification date in the space marked "RECERTIFICATION." Parenteral and enteral nutrition orders are ideally and initially verified or recommended by a licensed nutritionist-dietician. For continuation of nutritional therapy, a new PEN Authorization Form must be completed and resubmitted to the Program when it expires. Any change in the prescription requires completion of a Revised PEN Authorization Form.
Invoice Control Number (ICN):	Billing occurs monthly. Please enter the ICN corresponding to the first month of the certification span requested on the PEN Authorization Form. All months for the remainder of the certification span may be billed directly without completing or submitting a new PEN Authorization Form, unless that certification was denied. Providers are able to retrieve the ICN from remittance advice reports. All nutrition supplies are considered direct bill items and claims should be submitted to MMIS directly.
Participant Information:	Indicate the participant's name, permanent legal address, telephone number, Medicaid ID, and date of birth. Include the participant's weight, height, and sex.
DMS/DME Provider Information	Indicate the name of your company (provider name), address, provider number, NPI, as well as a specific contact person, phone number, and email.
Prescriber Information	Indicate the name of the prescriber, address, phone number, license number, and the last time the participant was seen by the prescriber.
Request Details	Enter the length of the need in months, diagnosis information, and any medical justification.
Rare and Expensive Case Management (REM)	For requests for REM participants who are neither tube-fed, nor have a metabolic disorder, providers must submit to the Program: 1) a comprehensive metabolic panel with Mg, phosphorus, and serum pre-albumin levels; 2) recent medical documentation supporting any weight loss over the past 6 month; and 3) dated CDC clinical growth charts for children 0-36 months (all plotted values must be legible); or 4) dated CDC clinical growth charts (ex. BMI-for-age chart, weight-for-age; statue-for age) from 2-20 years old participants (all plotted values must be legible). Continued use of nutritional supplements for REM participants will be reviewed by the Program every 6 months to a year depending on the case. For participants without evidence of medical need or proper documentation, **a one-time 30-day emergency supply** of the requested nutritional supplement will be pre-authorized until the proper documentation is received by the Program for determination of nutritional need.
Question Section	This section is used to gather clinical information about the requested items or services billed. Answer each question which applies to the items ordered.
Provider Attestation and Signature/Date	This section contains the provider's attestation, name, signature, and date.

PARENTERAL AND ENTERAL NUTRITION (PEN) AUTHORIZATION FORM

Certification Type/Date: Initial___/___/___ Revised___/___/___ Recertification___/___/___	
Invoice Control Number (ICN):	
Participant Information	**Prescriber Information**
Participant Name and Address	Prescriber Name and Address
Phone: (____)-_____-_____ Medicaid ID	Phone:(____)-_____-_____
Participant DOB ___/___/___	License Number _____NPI_____
Weight___(lbs/kg) Height ___ft. ___in. Sex ___ (M/F)	Last Seen by Prescriber ___/___/___
DMS/DME Provider Information	
Provider Name and Address	Contact Person (Optional)
Provider Number _____NPI_____	Phone:(____)-_____-_____ Email_____
Request Details	
EST. Length of Need (# of Months) ____1-12	Is participant in the REM Program? Y☐ N ☐
Diagnosis:	
Medical Justification:	

Answer	ANSWER QUESTIONS 1–8 FOR **ENTERAL NUTRITION**, AND 8–11 FOR **PARENTERAL NUTRITION** (Check Y for Yes, N for No, Unless Otherwise Noted)
Y☐ N ☐	1. Does participant have an inborn error of metabolism?
Y☐ N ☐	2. Is the enteral nutrition being provided for administration via tube? (i.e., gastrostomy tube, jejunostomy tube, nasogastric tube)?
___% of tube-feeding	3. If partially tube-fed, only amount that is actually tube-fed will be approved.
	4. Calories prescribed initially verified by (Prescribing Provider's Name)
A) _____	5. Print HCPCS requested.
B) _____	
A)	6. Calories per day for each corresponding HCPCS
B)	
1☐ 2☐ 3☐ 4☐	7. Check the number for method of administration. 1– Syringe 2 – Gravity 3 – Pump 4 – Oral (i.e. drinking)
___	8. **Days per week administered or infused (Enter 1–7)**
Y☐ N ☐	9. Is there documentation in the medical record that supports the participant having permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the participant's overall health status?
	10. Formula components: Amino Acid _____ (ml/day)_____concentration % _____ gms protein/day Dextrose_____ (ml/day)_____concentration % Lipids_____ (ml/day)_____days/week _____ concentration %
1☐ 2☐ 3☐	11. Check the number for the route of administration. 1 – Central Line (Including PICC) 2 – Hemodialysis Access Line 3 – Peritoneal Catheter

Provider Attestation and Signature/Date

I certify that I am the DMS/DME provider identified on this PEN Authorization Form and that the information provided is true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.

Name: _____	Signature_____	Date ___/___/___