Medi-Cal Provider Training 2024

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Durable Medical Equipment & Medical Supplies

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

The Outreach and Education services is made up of Regional Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at https://learn.medi-cal.ca.gov
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on www.medi-cal.ca.gov.

Regional Representatives

Receive one-on-one assistance from Regional Representatives who live and work in cities throughout California. Regional Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the Small Provider Billing Assistance and Training Program, call (916) 636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!

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Appendix 1

Acronyms 1

Durable Medical Equipment

Introduction

Purpose

The purpose of this module is to provide an overview of Durable Medical Equipment (DME) and program coverage.

Module Objectives

- Discuss policy and clarifications in Medi-Cal
- Understand *Treatment Authorization Request* (TAR) requirements
- Identify DME modifiers
- Review "By Report" attachment requirements
- Explain repair and maintenance policy
- Provide claim examples
- Review common denials

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Program Coverage

Medi-Cal covers DME when provided on a written prescription (or electronic equivalent) of a physician, nurse practitioner, clinical nurse specialist, or physician assistant. A recipient's need for DME items must be reviewed annually by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. For all DME items that require replacement or replacement parts, a new prescription for the DME item is required annually.

The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed DME items may be covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability.

A wheelchair is medically necessary if the beneficiary's medical condition(s) and mobility limitations are such that without the use of the wheelchair, the beneficiary's ability to perform one or more mobility related activities of daily living (ADL) or instrumental activities of daily living in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

Note: Per *California Code of Regulations* (CCR), Title 22, Section 51321(g): authorization for durable medical equipment shall be limited to the lowest cost item that meets the recipient's medical needs.

Nursing Facility Coverage

Canes, crutches, wheelchairs and walkers for Nursing Facility (NF) Level A and B recipients are only separately reimbursable when the item must be custom-made or modified to meet the unusual need of the recipient and the need is expected to be permanent.

DME Policies and Clarifications

Policies

- New codes and deleted codes: when a code is no longer valid and a TAR is required, providers must send in a new TAR with the new code.
- Changes are date-of-service driven.
- NCCI – National Correct Coding Initiative.
- Medi-Cal must follow Medicare frequency limits.

Policy Clarification and Changes

Face-to-Face Encounter

For all DME items a face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist or physician assistant that is related to the primary reason the recipient requires the DME item is required. Face-to-face encounters may be done via telehealth. For all DME items that require repair or replacement parts, a new prescription for the DME item is required annually.

The following conditions must be met in order for the face-to-face encounter to be satisfied:

- The provider performing the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the prescribing practitioner.
- The clinical findings from the face-to-face encounter must be incorporated into a written or electronic document included in the recipient's medical record.
- Practitioner prescribing the DME must document that the face-to-face encounter, which is related to the primary reason the patient requires the DME, has occurred within six months prior to the date on the DME prescription.
- Practitioner writing the DME prescription must document who conducted the face-to-face encounter and the date of the encounter.

Rental Reimbursement Cap

When previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and patient owned after 10 months of rental and no further reimbursement to the provider shall be made unless repair or maintenance of the item is separately authorized

- Repairs after the code has achieved "patient-owned" status is covered by Medi-Cal when providers use modifier **RB** for repair and document the code is "patient-owned."
- Claims for these items require a statement in the *Additional Claim Information* field (Box 19) or an attachment that the item is "patient-owned."

Note: The exception is for ventilator codes (E0465, E0466, and E0467), which are under continuous rental policy. Effective for dates of service on or after April 1, 2023, codes E0431, E0433, E0434, E0439, E0465, E0466, E0467, E1390, E1391 and E1392 are rental only and exempt from the 10-month rental cap.

Osteogenesis Stimulators

Authorization is required for the following osteogenesis stimulator devices. Additionally, a dated order for the osteogenesis stimulator and related supply items, signed by the treating practitioner, must be kept on file by the supplier of the equipment.

Code Descriptions for Osteogenesis Stimulator Devices Table

Code	Description
E0747	Osteogenesis stimulator; electrical, non-invasive, other than spinal applications
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive

All claims for an osteogenesis stimulator, electrical or ultrasound and related supplies must include an ICD-10-CM code that describes the condition and location requiring the device.

For nonunion condition of fractures, the claim must include both the ICD-10-CM code for nonunion of fracture and the specific fracture site.

Even though osteogenesis stimulators are returned and reused following completion of treatment, they must be authorized as a purchase item and billed with modifier NU, regardless of the period of use. These items may not be rented. The purchase-only reimbursement is all-inclusive of the following:

- All accessories necessary to use the unit (for example, electrodes, wires, gel, cables, etc.)
- Patient education on the proper use and care of the equipment
- Routine servicing and all necessary repairs or replacement to make the unit functional

These codes must also be billed with modifier KF as designated by Food and Drug Administration (FDA) as a class III device that supports or sustains life.

Heated Humidifiers and Breathing Circuits Not Reimbursable with Ventilator Rentals

Effective for dates of service on or after July 1,2023, Medi-Cal will not provide a separate reimbursement payment for humidifiers, options, accessories or supplies when ventilator HCPCS codes E0465, E0466 or E0467 are used.

The Department of Health Care Services (DHCS) is updating the Medi-Cal rental policy for ventilators to coincide with Medicare’s policy for ventilator rentals.

Note: A9900 and S8189 should not be used to bill ventilator/heated circuits as they are included with the reimbursement of the ventilator (E0465/E0466/E0467).

Purchased only policy:

- Modifier **NU** is required for codes that are purchase-only.
- During the month of purchase, Medi-Cal does not pay for supplies or repairs.
- Purchased DME items have a warranty period in which the manufacturer is to pay for any repairs/replacements.
- After the warranty period expires, providers must use required modifier **RB** when repairs are needed.
- The frequency limit policy must be observed before the same item can be purchased again. The exception is medical necessity under unforeseen circumstances by submitting a *Treatment Authorization Request* (TAR).
- Some DME items can either be rented (if it is a short period of time), or purchased (for long term use).
- Codes are given “required” modifier **RR** for rental, required modifier **NU** for purchase, and required modifier **RB** for repairs.
- A code cannot be reimbursed if modifier **RR** is used during the same month as modifier **NU**. The item cannot be repaired during its rental period and the provider is responsible for all supplies associated with the code along with any repairs during its rental period.

Rental Policy for Intrapulmonary Percussive Ventilators/Devices

Rental policy for HCPCS code E0481 (intrapulmonary percussive ventilation system and related accessories) requires modifier RR on the claim during the rental period. Following ten consecutive months of rental, the device will be considered patient owned. After the device is patient-owned, providers must use modifier RB when repairs are required, and modifier NU must be used for supplies.

Medical Criteria for Respiratory Durable Medical Equipment Codes

The medical criteria for HCPCS Codes E0481 (intrapulmonary percussive ventilators and devices), E0482 (cough stimulating device) and E0483 (high frequency chest wall oscillation system) has been updated. Updates include:

- E0481: An intrapulmonary percussive ventilator is not reasonable nor necessary in a home setting and will be denied as not medically necessary.
- E0482: A Treatment Authorization Requests will be denied if the patient does not have a neuromuscular disease diagnosis and a condition causing significant impairment of the chest wall and/or diaphragmatic movement.
- E0482, E0483: It is not reasonable or necessary for a patient to use both a cough stimulating device (E0482) and a high frequency chest wall oscillation device (E0483).
- E0483: A confirmed diagnosis of bronchiectasis must be present in order to meet the criteria. Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion.

Rental Policy for Oscillation System

The rental policy is updated for HCPCS code E0483 (high frequency chest wall oscillation system, includes all accessories and supplies, each). Modifier RR is required on the claim during the rental period. Following ten months of rental, the device will be considered patient owned. Modifier RB is not allowed or reimbursable during rental period. Any allowed repairs or supplies can be reimbursed after ten months of rental when provider indicates that the item is patient-owned.

Guidance for Respiratory DME Codes E0482 and E0483

- The medical criteria for HCPCS codes E0482 (cough stimulating device) and E0483 (high frequency chest wall oscillation system) has been updated.
- Previously providers were told “It is not reasonable or necessary for a patient to use both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483)”. This guidance has since been amended to “It is generally not necessary for a patient to use both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483).
- However, if both devices are needed for a patient, a TAR/SAR is required and must indicate the specific medical necessity that the use of both a cough stimulating device (E0482) and a high frequency chest wall oscillation (HFCWO) device (E0483) are necessary.

Continuous Glucose Monitoring and Disposable Insulin Delivery Devices

Effective for dates of service on or after December 1, 2022, the following HCPCS codes for CGM and DIDD are no longer covered by DME policy:

HCPCS Code	Description
A9276	Sensor; invasive (e.g., subcutaneous) disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply
A9277	Transmitter; external, for use with interstitial continuous glucose monitoring system
A9278	Receiver (monitor); external, for use with interstitial continuous glucose monitoring system
K0553	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service
K0554	Receiver (monitor), dedicated, for use with therapeutic glucose monitor system

Scales

HCPCS code E1639 (scale, each), claim. For reimbursement, documentation must indicate that the recipient does not have access to a scale and meets one of the following criteria:

- Enrolled in the Medi-Cal Diabetes Prevention Program.
- Recipient is pregnant.
- Recipient has a medical condition which requires ongoing monitoring of weight from home such as: CHF (Congestive Heart Failure), ESRD (End Stage Renal Disease) and on dialysis, peripheral vascular disease/lymph edema, and hypertension on diuretic medication.

Refer to the *Durable Medical Equipment (DME): Other DME Equipment* section (dura other) of the Part 2 provider manual.

Phototherapy Light for Infants

HCPCS code E0202 (phototherapy[bilirubin] light with photometer) is a Medi-Cal benefit for infants as a daily rental only. Because the light is rented, modifier RR is required. For reimbursement, documentation must indicate that the recipient meets the following criteria:

- The infant's total serum bilirubin is in the "optional range" as defined by the American Academy of Pediatrics Subcommittee on Hyperbilirubinemia; and
- The infant is feeding voiding and stooling well and appears well; and
- Close follow-up evaluation can be accomplished.

Claims submitted to bill for the phototherapy light may be submitted under the mother's Medi-Cal ID if the infant's Medi-Cal eligibility has not yet been established. Claims that use the mother's Medi-Cal ID for the infant, must indicate in the *Patient Relationship to Insured* field (Box 6) that the "patient is the child of the insured".

The frequency limit for HCPCS code E0202 is 10 days per lifetime, per infant. A *Treatment Authorization Request* (TAR) can override the frequency limit when more than one infant born to the same mother (for example, twins, or infant from subsequent birth) requires phototherapy. When phototherapy is needed for more than one infant, claims for phototherapy require a statement in the *Additional Claim Information* field (Box 19) specifying the number of infants needing phototherapy at this time or that a previous claim was submitted for a sibling who also required phototherapy.

Refer to the *Durable Medical Equipment (DME): Other DME Equipment* section (dura other) of the Part 2 provider manual.

Portable Ramps

A fixed, modular or in any way attached ramp is considered a non-portable ramp and is not a Medi-Cal benefit. Portable ramps are those that are foldable or collapsible, not attached, suitcase types, which can be easily and readily carried and transported by the recipient for use in multiple locations. The portable ramp usually weighs no more than 90 pounds or measures no more than 10 feet in length.

Breastfeeding

When submitting claims for the **purchase** or **rental** of lactation management aids and replacement supplies, follow the criteria and documentation requirement guidelines listed in the *Durable Medical Equipment (DME): Other DME Equipment* section (dura other) of the Part 2 provider manual. Replacement supplies cannot be purchased the same month of the purchase of a pump. All supplies are included in the rental or initial purchase of a breast pump.

Supplies for Cough Stimulating Device

When submitting TARs or claims for supplies or replacement parts for HCPCS code E0482 (cough stimulating device, alternating positive and negative airway pressure), providers must use code A7020 (interface for cough stimulating device, includes all components, replacement only). Claims that bill with codes A7027 through A7046 (CPAP and BI-PAP) with code E0482 will be denied, regardless of whether the recipient owns the device or if Medi-Cal is renting the device. HCPCS code A7020 is not separately reimbursable when billed with the rental and/or purchase (within the same month of service) of the cough stimulating device.

Shipping and Handling

Shipping and handling costs for Durable Medical Equipment and Orthotics and Prosthetics (O&P) are not reimbursed by Medi-Cal.

Date of Service

The delivery date of the DME equipment to a recipient is the date of service. This means that when the recipient receives the DME item delivered by the provider, that date is considered the date of service.

Product Classification

Medi-Cal approximates Medicare's product classification and equipment policies on coverage for medical equipment.

Product Classification

Topic	Website Location
Local Medical Review Policies	*(www.noridianmedicare.com)* *(www.dmepac.com)*

Code Frequency Limits

- Frequency limits for each code are listed in the *Durable Medical Equipment (DME) Billing Codes: Frequency Limits* section (dura cd fre) of the Part 2 provider manual.
- Service Authorization Requests (SARs), TARs and/or a CCS authorization can override these limits.
- Limits cannot be exceeded on the same date of service even with an authorization. The provider must submit the claim with different dates of service.

Warranties

- It is the provider's responsibility to check all warranties on a piece of equipment. If the equipment is still under warranty, the provider must work with the manufacturer for replacement or repair of that item at no charge to the Medi-Cal program.
- Pursuant to CCR, Title 22, Section 51321 (i) and (j), rendering providers of DME shall ensure that all devices and equipment are appropriate to meet the recipient's medical needs. Providers shall instruct recipients in appropriate use and care of DME and notify recipients that they are responsible for appropriate use and care of DME purchased for their use under the Medi-Cal program. If a piece of equipment or a device when in actual use fails to meet the recipient's needs, and the recipient's medical condition has not significantly changed since the device/equipment was dispensed, the rendering provider shall adjust or modify the equipment, as necessary, to meet the recipient's needs. The rendering provider, at no cost to the Medi-Cal program, shall replace any equipment or device that cannot be adjusted or modified.

Reimbursement Limit – Upper Billing Limit

Reimbursement for DME is subject to the Upper Billing Limit defined in CCR, Title 22, Section 51008.1. Bills submitted are not to exceed an amount that is the lesser of:

- The usual charges made to the general public, or
- The net purchase price of the item, which must be documented in the provider's books and records, plus no more than a 100 percent markup.

For procedure codes that have a listed maximum allowable DME purchase billing amount, the amount billed should not exceed the net purchase price of the item, plus 100 percent markup.

California Children's Services (CCS) Only Benefits

The following Healthcare Common Procedure Coding System (HCPCS) codes are not Medi-Cal benefits and must be approved through the CCS branch for children younger than 21 years of age. See the *Durable Medical Equipment (DME): Billing Codes for California Children's Services* section (dura cd ccs) in the appropriate Part 2 provider manual for a complete list.

Table of Non Medi-Cal Benefit HCPCS Codes

Code	Description
E0635	Patient lift, electric, with seat or sling
E0639	Patient lift, movable from room to room with disassembly and reassembly, includes all components/accessories

If a Medi-Cal recipient requires one of the above items, use the appropriate code when submitting a request to the Medi-Cal field offices. If an age restriction exists, a TAR may override it.

Accessing the Medi-Cal Providers Homepage

The Medi-Cal Providers website home page can be accessed by opening an internet browser, typing *mcweb.apps.prd.cammis.medi-cal.ca.gov* in the address bar and pressing **Enter**.

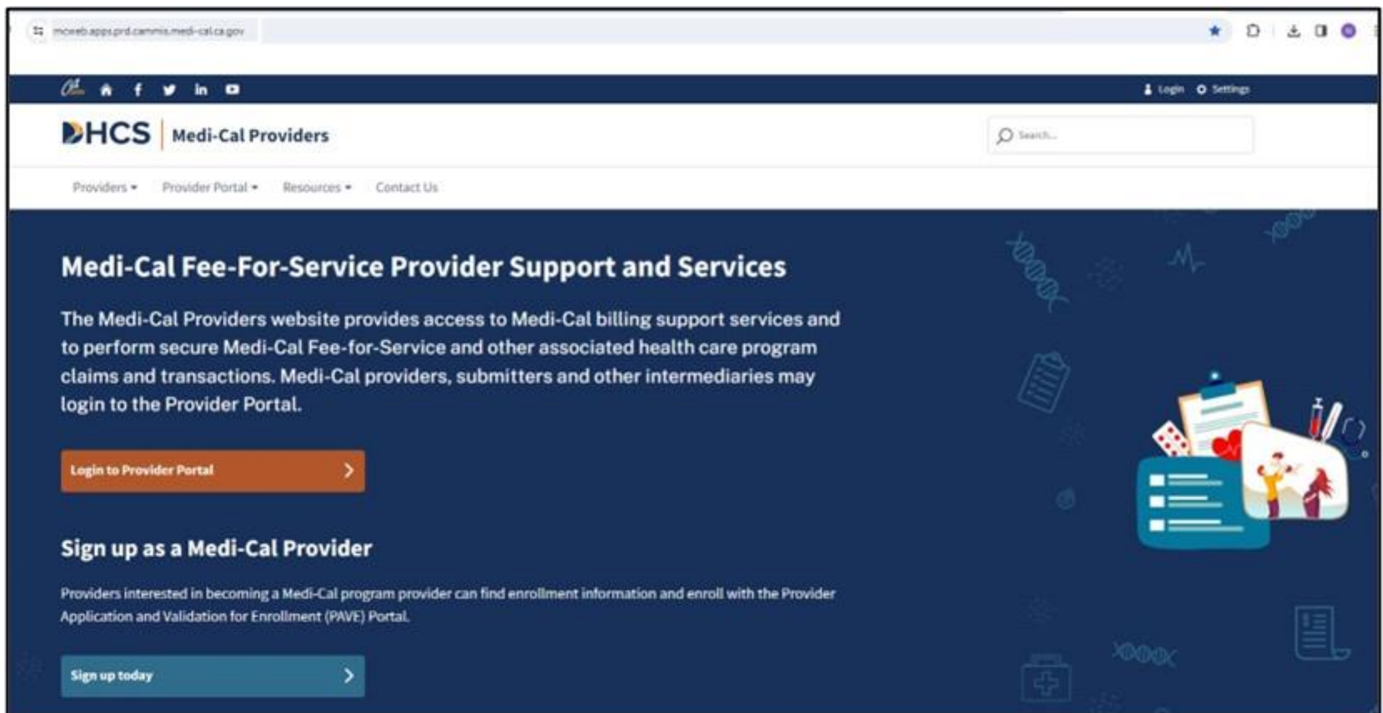

Figure 1.1: Medi-Cal Provider Homepage.

To access provider communities and their associated reference materials, navigate to Publications from the Providers drop-down menu.

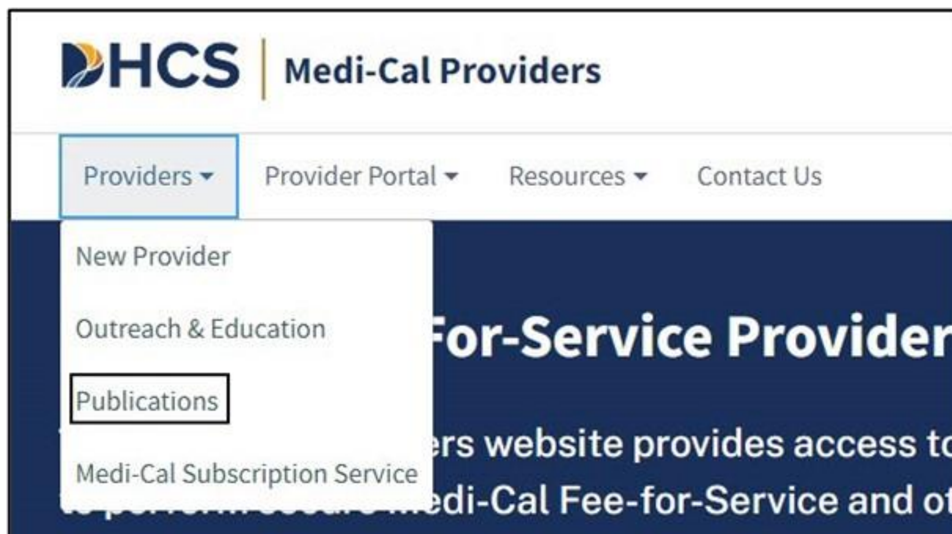

Figure 1.2: The Providers drop-down menu on the Medi-Cal Provider homepage.

The services offered within Medi-Cal are shown on the Publications page. Under **Allied Health Communities**, select **Durable Medical Equipment and Medical Supplies.**

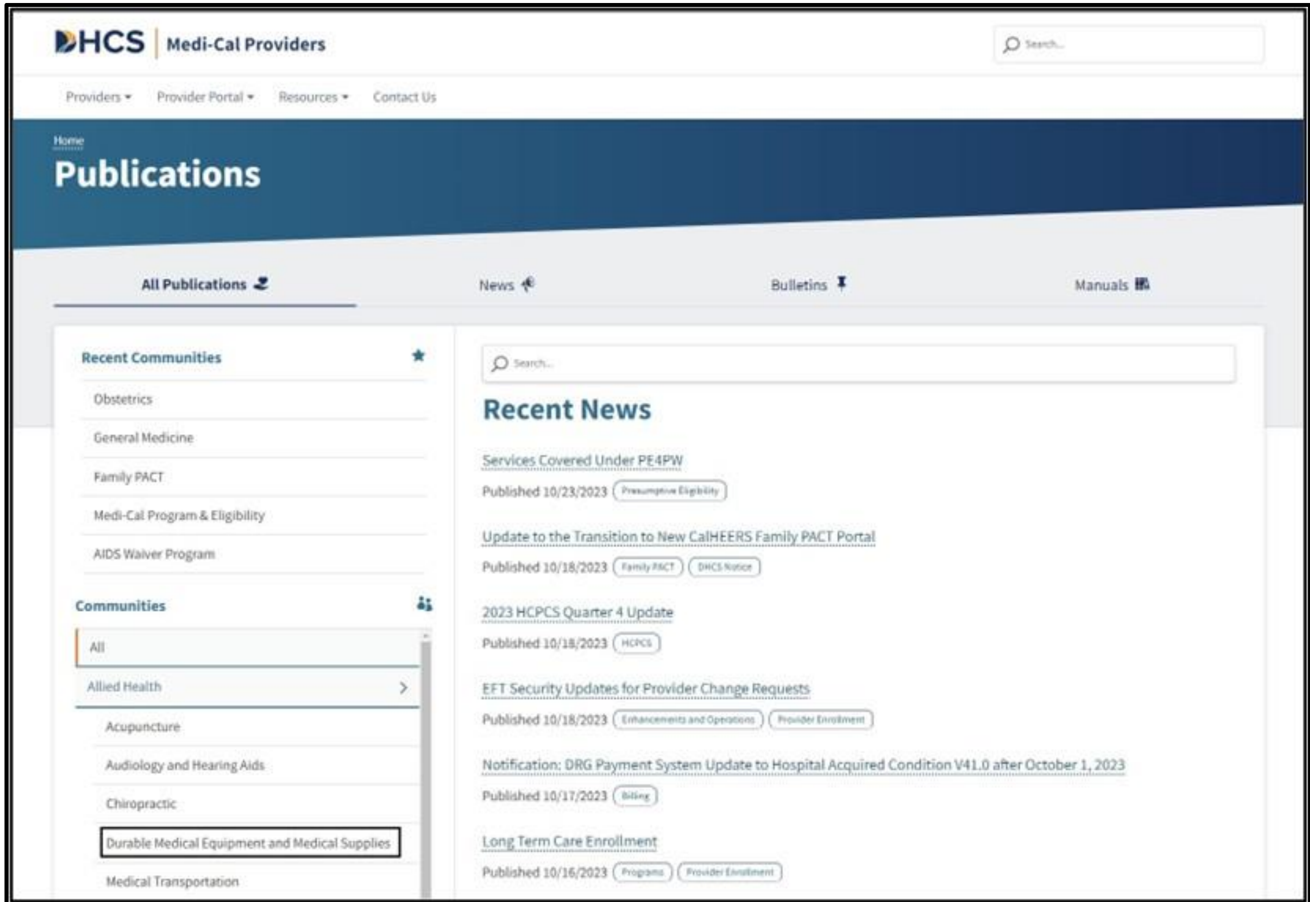

Figure 1.3: All provider communities may be accessed individually from the Medi-Cal Provider Publications homepage.

Once you have clicked on your desired provider community, the community-specific page will appear. Every provider community page contains:

- Bulletins.
- News.
- Provider Manuals.

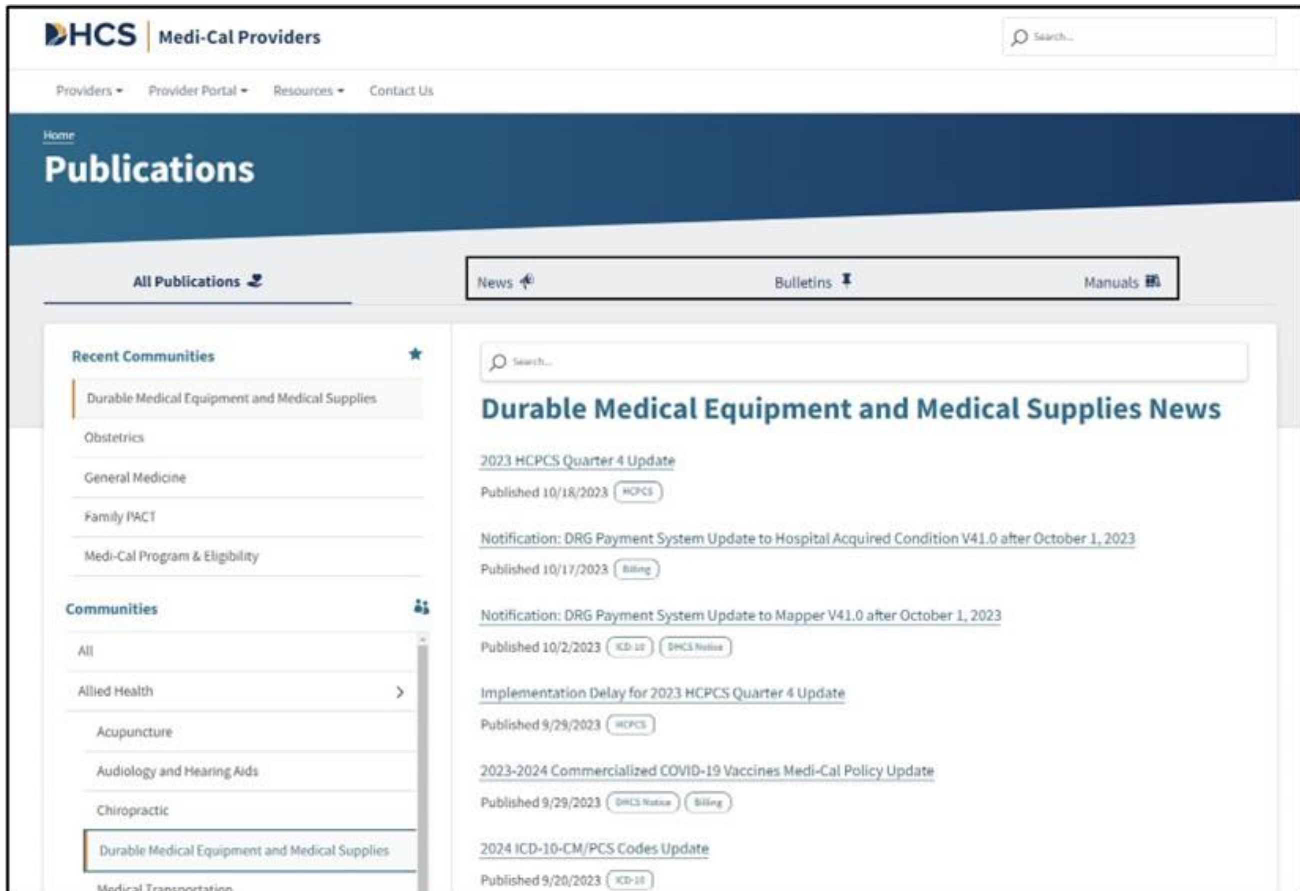

Figure 1.4: Publications Navigation Bar serves as a starting point for providers to access published materials for all communities.

Billing

DME Modifiers

Table of DME Modifiers

Modifier	Modifier and Description
NU	New equipment
RR	Rental
RB	Replacement as part of repair
KC	Replacement of special power wheelchair interface
KF	Item designed by FDA as Class III device
QA	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than one liter per minute (LPM)
QB	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds four LPM and portable oxygen is prescribed
QE	Prescribed amount of stationary while at rest is less than one LPM
QF	Prescribed amount of stationary oxygen while at rest exceeds four LPM and portable oxygen is prescribed
QG	Prescribed amount of stationary oxygen is greater than four LPM
QR	Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is greater than four LPM
SC	Medically necessary service or supply (used for second unit of oxygen content)

Tax Status for DME Codes

In accordance with California Department of Tax and Fee Administration (CDTFA) regulation 1591, tax status is updated for the following Durable Medical Equipment (DME) HCPCS codes:

Providers should refer to the *tax* section in the *Durable Medical Equipment and Medical Supplies* (DME) manual for a complete list.

When billing for an unlisted code that is "By Report," indicate whether or not the item is taxable in the *Additional Claim Information field* (Box 19) of the *CMS-1500* claim form or on an attachment. When using a listed code with an allowable rate, the system will pay the tax, if applicable. Providers must include sales tax on Medi-Cal claims for taxable supplies and equipment. If sales tax is not included in the billed amount, the sales tax amount will not be included in the reimbursement.

Rentals

All accessories are included in the rental reimbursement. Billing separately for accessories while billing for the rental will cause the accessories to deny or the amount to deduct from the rental. The accessories may be reimbursed separately after the recipient owns the piece of equipment.

Authorization Requirements

Authorization is required under the following circumstances:

- Cumulative cost within the calendar month for purchase of DME within a group exceeds $100.00.
- Cumulative cost within a 15-month period for rental of DME within a group exceeds $50.00.
- Respiratory equipment and accessories require authorization regardless of dollar amount.
- Cumulative cost within the calendar month for repair or maintenance exceeds $250.00.
- Request is for any unlisted or “By Report” item, regardless of dollar amount.

Prescriptions

The following must be supplied with the prescription for DME rental or purchases:

- Full name, address, telephone number and license number of prescribing practitioner.
- Date of prescription.
- Items being prescribed.
- Medical condition necessitating the particular DME item.
- Estimated length of need.
- For wheelchair and wheelchair accessories, refer to the *Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines* section (dura wheel guide) of the Part 2 provider manual.

Certificates of Medical Necessity

Certificates of Medical Necessity are available online and in the appropriate Part 2 provider manual.

- Respiratory
  - Apnea monitors – MC 4600
  - Nebulizers – MC 4601
  - Oxygen – MC 4602
- DME Equipment
  - Non-wheelchairs – DHCS 6181
- Wheelchairs
  - Manual wheelchairs – DHCS 6181A
  - Power wheelchairs – DHCS 6181B
  - Power Operated Vehicles (POVs) – DHCS 6181C

TARs

The following items must be included on the TAR. See the *TAR Completion* section (tar comp) in the appropriate Part 2 provider manual for a complete list:

- Date of request.
- Recipient's address.
- HCPCS code and item description.
- Justification for using an unlisted code.
- Copy of prescription.
- Medical necessity documentation for item being requested.
- If a "By Report" item, attach appropriate Manufacturer's Suggested Retail Price (MSRP) catalog page.
- Rendering provider and contact information (name and phone number).

Documentation Requirements

Documentation submitted with the TAR for wheelchairs must include the following:

- The mobility and seating impairment to be accommodated.
- Equipment currently owned by the recipient, detailed features of the DME item and the date of purchase.
- Verification and documentation that other treatments of lesser mobility devices do not safely accommodate the recipient's mobility impairment.
- Verification and documentation that the requested equipment fits and is usable in all living areas used by recipient.
- An explanation describing how the living areas will be accessed by the recipient with the requested equipment.
- Verification and documentation that the recipient and/or caregiver understands how to care for and use the requested equipment.

- Seating evaluation by a qualified therapist (Occupational Therapist (OT)/ Physical Therapist (PT)/Assistive Technology Professional (ATP) for the following:
  - Neurological conditions
  - Complex orthopedic along with neurological conditions
  - Pediatric wheelchairs

Refer to the *Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories* section (dura bil wheel) and *Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines* section (dura wheel guide) in the appropriate Part 2 provider manual for information.

Bundle all accessories with the basic piece of equipment under the main code. For example:

- Gait trainers: Codes E8000 through E8002
- Bath bench: Code E0240
- Standing frames: Codes E0637, E0641 and E0642
- Position seat: Code T5001

Do not use the main code and then add all accessories under code E1399 (durable medical equipment, miscellaneous). This can cause problems when billing the claim.

The information on the invoice must match the information on the MSRP catalog page.

Refer to the Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed Products (dura thp) in the appropriate Part 2 provider manual for information.

In addition to the documentation requirements specified above, all initial and reauthorization TARs for support surfaces must be accompanied by the appropriate flowcharts(s), based upon the patient's medical condition and the specific support surface needed to meet the patient's medical need(s).

- The provider must indicate (circle or highlight) the appropriate answer to all questions on the flowchart(s), based upon the documentation in the patient's medical record.
- If the appropriate flowchart(s) is not submitted or the information provided on the flowchart(s) and TAR is not sufficient to determine medical necessity for the requested support surface, the TAR shall be deferred for the required information. If the TAR has been previously deferred and the required information has not been submitted by the provider, the medical consultant shall deny the TAR.
- For unlisted procedure codes, the provider must submit the most appropriate flowchart(s), based upon the documentation in the patient's medical record. The flowchart(s) must be completed to the extent possible, along with justification for the requested unlisted procedure code.

Equipment

Oxygen/Respiratory Therapy

Criteria Expansion for Oxygen and Respiratory Equipment

The criteria for DME oxygen contents and oxygen equipment and respiratory equipment has been revised to align Medi-Cal policy with Medicare policy. The revision includes requirements for blood gas studies and other clinical criteria that must be met to qualify for supplemental oxygen. Blood Gas studies, Arterial Blood Gas (ABG), is a partial criterion that is used to qualify for either a ventilator, or a BiPap ST. This test shows that the patient is in respiratory failure. An ABG or an external pulse oximetry are the tests that are used to qualify for oxygen (either one), with the latter being used exclusively for a nighttime oxygen request. Portable oxygen systems have also been revised. For more information, refer to the *Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment* section (dura oxy) in the Part 2 provider manual.

Reimbursement for listed oxygen therapy service codes will not exceed 80 percent of the California Medicare reimbursement rates.

A TAR/SAR is required for all respiratory DME except for the following, which require authorization only for quantities exceeding the stated billing limit:

- A7005 (administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable) – billing limit of one in six months.
- E0484 (oscillatory positive expiratory pressure device, non-electric, any type, each) – billing limit of two in 12 months.

Portable Oxygen

Code E0443: Oxygen Contents (Gas)

Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), a one-month supply = one unit.

- For Medi-Cal purposes, code E0443 can be used to bill for portable gaseous oxygen contents, whether the portable system is rented or purchased.

Note: One unit is defined as "250 cubic feet" for the first supply of contents and any amount for the second supply of contents (second unit).

- Modifier NU must be used when billing code E0443 for the first unit and modifier SC must be used for the second unit. A maximum of two units is allowed per month.

For example:

Table of Modifier and Billing Code Example

Billing Code	Quantity
E0443NU	quantity of 1
E0443SC	quantity of 1

Code E0444: Oxygen Contents (Liquid)

Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), a one-month supply = one unit.

- For Medi-Cal purposes, code E0444 can be used to bill for portable liquid oxygen contents whether the portable system is rented or purchased.
- Modifier NU must be used when billing code E0444 for the first unit and modifier SC must be used for the second unit. A maximum of two units is allowed per month.

Note: One unit is defined as "110 pounds" for the first supply of contents and any amount for the second supply of contents (second unit).

For example:

Table of Modifier and Billing Code Example

Billing Code	Quantity
E0444NU	quantity of 1
E0444SC	quantity of 1

- Only two units can be approved per month. A TAR/SAR will not override this limit.

Oxygen Specific Modifiers

Rented Equipment

Codes E0424, E0439, E1390, E1391: Oxygen Flow Rate

The following modifiers are billed only with stationary gaseous (E0424) or liquid (E0439) systems or with a non-portable oxygen concentrator (E1390, E1391).

Table of Oxygen Specific Modifiers

Modifier	Oxygen Flow Rate	Reimbursement Rate
RR	1 thru 4 LPM	$136.87
QE or QA	Less than 1 LPM	$68.44 (reduced by 50 percent)
QF or QB	Greater than 4 LPM Portable oxygen is prescribed	$205.31
QG or QR	Greater than 4 LPM Portable oxygen is not prescribed	$205.31

Use only one modifier when billing with the above modifiers. Multiple modifiers will result in a denied claim.

For example:

- E1390RR
- E1390QG

Notes:

Wheelchairs

Claim Requirements for "By Report" Wheelchairs

Claims must include the information about the technician involved in the evaluation, delivery and final fitting of the wheelchair. In the *Additional Claim Information* field (Box 19) or by attachment, include the following:

- The name and title of the employed or contracted qualified rehabilitation professional. Acceptable titles include:
  - Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified technician.
  - Certified Rehabilitation Technology Supplier (CRTS).
  - Licensed California physical therapist (PT).
  - Licensed California occupational therapist (OT).

For example: *Additional Claim Information* field Box 19 – Tom Smith, RESNA.

Reimbursement Conditions

Reimbursement will be the lesser of:

- 85 percent of MSRP catalog dated on or prior to the date of service, or
- Manufacturer's purchase invoice (cost), amount, plus 67 percent markup, or
- Amount billed pursuant to CCR, Title 22, Section 51008.1.

If the claim does not provide documentation that the provider employs or contracts with a qualified rehabilitation professional, reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service, or
- Manufacturer's invoice, plus 67 percent markup, or
- The billed amount.

Wheelchair "Replacement Only" Parts

Wheelchair parts that include a description of "replacement only" should be billed using NU not RBNU/NURB.

- The claim will be denied when using the wrong modifiers. Providers need to check each code on the repairs to see what modifier to use.

Unlisted DME Non-Wheelchairs Claim Reimbursement Conditions

Reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service or
- Manufacturer's invoice plus 67 percent markup or
- The billed amount

Claim Requirements for Unlisted DME Supply HCPCS “A” Codes

Claims must include the following information to receive reimbursement:

- In the *Additional Claim Information* field (Box 19), a statement that the equipment is “patient owned” and either the description of the equipment or the procedure code of the owned equipment must be included.

For example:

Patient-owned nebulizer with compressor E0570.

When to Bill A9900 and E1399

HCPCS code E1399 is used when an active HCPCs code does not exist for **non-wheelchair miscellaneous equipment or the repairs** of E1399 equipment.

E1399 is not to be used for medical supplies, it is for DME only. Even if they have a TAR/SAR the claim will be denied.

A9900 is used for **miscellaneous supplies** that do not have an active HCPCS code.

Reimbursement Conditions A9900

Reimbursement will be the lesser of:

- Manufacturer’s purchase invoice, plus a 23 percent markup or
- The billed amount

Non-Wheelchair Miscellaneous Equipment E1399 and Blood Pressure Monitors HCPCS A4670

Reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service or
- Manufacturer’s invoice plus 67 percent markup or
- The billed amount

"By Report" Attachment

- For custom-made equipment with no MSRP available, submit the manufacturer's purchase invoice. If the invoice does not indicate that the item is "custom," handwrite a statement on the invoice "custom and no MSRP available."
- If there is no MSRP available for the item billed, submit the manufacturer's invoice and explain the lack of MSRP.
- If the provider writes "No MSRP available" but the medical review team knows the manufacturer has an MSRP the claim will be denied.
- If the provider is renting the piece of equipment from another provider or manufacturer, and unable to purchase, submit the rental invoice showing the rental cost and the appropriate MSRP catalog page.
- When the provider and the manufacturer are the same, attach the MSRP or catalog page with the appropriate date.

Approved attachments for DME claims

- MSRP catalog page dated on or prior to the date of service.
- Manufacturer's invoice dated prior to the date of service.
- Manufacturer quotes if MSRP is not available along with a manufacturer purchase invoice.
- Manufacturer's invoice dated prior to date of service, with MSRP on the same page.

Equipment Repair/Maintenance

- Medi-Cal only repairs equipment owned by the Medi-Cal patient.
- Labor codes:
  - K0739: all equipment except oxygen.
  - There is no separate reimbursement for K0739 with the Power Wheelchair battery replacement.
  - K0740: oxygen.
- Do not use a modifier with the labor code.
- Bill the labor time needed to accomplish the work in 15-minute units. The labor time may be rounded to the nearest half-hour for the total repair job.

For example:

1 hour and 20 minutes = 6 units.

- Hourly labor payment rate for DME repair is $65.88 (one 15-minute "unit" is $16.47).

Patient-Owned Equipment

Wheelchairs

Claims for the repair of wheelchairs (modifiers NU and RB) require the following information:

- In the Additional Claim Information field (Box 19) provide a description of the equipment and that the equipment is patient owned.

For example:

Box 19: Repair of patient-owned manual wheelchair K0005 (ultralightweight wheelchair).

- Use modifiers NU and RB for replacement of wheelchair parts.

Note: Use modifier NU only if the part has "replacement" only in the description.

Example of Modifiers used for Replacement of Wheelchair Parts

Billing Code	Wheelchair Parts
E2211NURB	Pneumatic tires
K0739	Labor

Non-Wheelchairs

Claims for the repair of non-wheelchair equipment (modifier RB) requires the following information:

- Box 19: Statement that the equipment is owned by the patient, e.g. “Repair of patient owned patient lift or patient owned E0630.”
- Description of service provided.
- Reason/justification for repair.
- Manufacturer’s name.

Do not bill for more than the quantity of (1) when repairing a non-wheelchair piece of equipment. The claim will be denied for exceeding the NCCI edit. Bill with (1) unit and include all the pieces of the parts you replaced on the attachment.

List of parts used, including catalog numbers and cost for “By Report” items.

For example:

Example Table for Non-Wheelchair Equipment Billing Codes

Billing Code	Parts Used
E0630RB	Patient Lift
K0739	Labor

Oxygen

Claims for repair of oxygen equipment (modifier RB), require the following information.

- Box 19: Statement that the oxygen equipment is owned by the patient.
- Description of service provided.
- Reason/justification of repair.
- Manufacturer’s name.
- List of parts used, including catalog numbers and cost for “By Report” items.

For example:

Example Table of Oxygen Equipment Modifier

Billing Code	Parts Used
E1354RB	Wheeled O2 Cart
K0740	Labor

DME Billing Example

Scenario 1: Listed DME

This is a sample only. Please adapt to your billing situation.

- Referring physician's name and NPI number are entered in the *Name of Referring Provider* or *Other Source* field (Box 17) and *NPI* field (Box 17B) because a written prescription is required for all DME rental and purchases.
- The DME company is billing for a wheelchair exceeding the cumulative cost of $100, authorization is required; therefore, the TAR number is entered in the *Prior Authorization Number* field (Box 23).
- The DME company is billing for the purchase of a standard wheelchair and an extra wide seat. HCPCS codes K0001 (standard wheelchair) and E1298 (special wheelchair seat) are billed with modifier NU (new equipment purchase) and entered in the *Procedures, Services or Supplies* field (Box 24D).
- Enter the usual and customary charges in the *Charges* field (Box 24F).

Note: Wheelchairs, their modifications and/or accessories are nontaxable.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. ROBERT BROWN

17a. 17b. NPI 1239874560

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 98765432101

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 22		12		K0001	NU		977 00	1		NPI	
2	10 01 22		12		E1298	NU		466 00	1		NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 1443 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Jane Smith* DATE 10/30/22

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555
ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. b.

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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Figure 2.1: Listed DME.

DME Billing Example

Scenario 2: Gas Oxygen System Rental with Modified Oxygen Flow

This is a sample only, please adapt to your billing situation.

- Claim example shows the rental of stationary gas oxygen system at less than 1 liter per minute oxygen flow rate (E0424QE)
- Referring physician's name and NPI number are entered in the *Name of Referring Provider or Other Source* field (Box 17) and NPI field (Box 17B) because a written prescription is required for all oxygen equipment rentals, purchases, and supplies
- TAR is required for all oxygen equipment and supplies.TAR number) number is entered in the *Prior Authorization Number* field (Box 23)
- The rental of a stationary gas oxygen system (E0424) is entered in the *Procedures, Services, or Supplies* field Box 24D.because the prescribed oxygen flow rate to be delivered by the stationary gas oxygen system is less than 1 liter per minute (LPM)
- Code E0424 is billed with modifier QE
- Enter the usual and customary charges in the *Charges* field (Box 24F)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA CARRIER

1. MEDICARE (Medicare#) MEDICAID X (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 93 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES X NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR. ROBERT BROWN

17a. 17b. NPI 1239874560

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 98765432101

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 01 22				E0424	QE		99 02	1		NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 99 02

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED *Jane Smith* DATE 10/30/22

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

ACME EQUIPMENT
1027 MAIN STREET
ANYTOWN CA 958235555

a. b.

PHYSICIAN OR SUPPLIER INFORMATION

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Figure 3.1: Gas Oxygen System Rental with Modified Oxygen Flow.

DME Common Denials

Remittance Advice Details

Table of Remittance Advice Details

Code	Description
0005	The service billed requires an approved TAR (*Treatment Authorization Request*).
0037	Health Care Plan enrollee, capitated service not billable to Medi-Cal.
0640	Recipient is not eligible for Medi-Cal benefits without complete denial of coverage from the Medicare Health Maintenance Organization (HMO), Competitive Medical Plan (CMP) or Health Care Prepayment Plan (HCPP). Medi-Cal is not obligated for plan services when the recipient chooses not to go to a plan provider.
0008	The provider of service is not eligible for the type of services billed.
0051	Signature is missing or is not an original.
0155	The referring provider's State license number or provider number is missing or invalid.
9670	Claim date of service does not match date of service on SAR (Service Authorization Request) file.
0314	Recipient is not eligible for the month of service billed.
0243	The TAR Control Number submitted on the claim is not found on the TAR master file.
0006	The date(s) of service reported on the claim is not within the TAR (*Treatment Authorization Request*) authorized period.
0672	The claim exceeds the monthly reimbursement limit for incontinence supplies.
9671	Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program).
9598	A statement that says "the equipment is patient-owned", and includes the specific procedure code and/or description of the equipment being repaired/serviced, is missing from the Additional Claim Information field (Box 19) of the claim or attachment.
9898	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.
9654	Manufacturer invoice and catalog page are required.
9098	The attached **documentation** is invalid.

Table of Remittance Advice Details (continued)

Code	Description
0225	Incorrect procedure code and/or modifier.
9006	This medical supply is not payable without a copy of the supplier's invoice.
9713	The date on the catalog or invoice is missing or invalid.
9217	Indicate a line number next to the catalog number.
9019	Information on the claim does not match what is being billed.
0031	The provider was not eligible for the services billed on the date of service.
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.

Claims checklist to avoid receiving common denials

- Sign your claim – Signature on file or typed in is not acceptable.
- Complete 11-digit TAR/SAR number – although not required, suggest attaching a copy of TAR/SAR so corrections can be made.
- Verify DOS is within the approved dates on TAR/SAR.
- Verify modifier and procedure are correct and match the TAR/SAR.
- Verify all required documentation is attached.
- Verify quantity is within the NCCI frequency limits (cannot be exceeded on the same Date of Service).

Notes:

Resource Information

References

Provider Manual References

The following reference materials provide Medi-Cal billing and policy information:

Part 1

Remittance Advice Details (RAD) and Medi-Cal Financial Summary (remit)

Part 2

Durable Medical Equipment (DME): An Overview (dura)

Durable Medical Equipment (DME): Billing Codes for California Children's Services (dura cd ccs)

Durable Medical Equipment (DME): Bill for DME (dura bil)

Durable Medical Equipment (DME): *Other DME Equipment* (dura other)

Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment (dura oxy)

Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories (dura bil wheel)

Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates (dura cd)

Durable Medical Equipment (DME) Billing Codes: Frequency Limits (dura cd fre)

Durable Medical Equipment (DME): Billing Examples (dura ex)

Durable Medical Equipment (DME): Modifiers: Approved List (modif app)

Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed (dur thp)

Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (dura wheel guide)

Medical Supplies

Introduction

Purpose

The purpose of this module is to provide participants with detailed information on medical supply billing, including claim examples, billing tips and the most common medical supply denials.

Module Objectives

- Explain coding requirements for HCPCS and UPN
- Provide provider manual reference for contracted and non-contracted products
- Detail claim form placement on the *CMS-1500* claim form for the UPN product qualifier and unit of measure
- Understand the reimbursement policy
- Review billing tips and the top ten common medical supply denials

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

Description

Federal HIPAA requirements mandate that states bill using the *CMS-1500* claim form and HCPCS Level II codes for disposable medical supplies and incontinence supplies.

For a complete list of HCPCS billing codes for medical supplies and incontinence supplies, refer to the *Medical Supplies* (mc sup) and the *Incontinence Medical Supplies* (incont) sections of the Part 2 provider manual.

For contracted medical supplies and incontinence supplies, a Universal Product Number (UPN) is required in addition to the Level II HCPCS code to allow for accurate pricing and tracking purposes. This is a California state billing requirement.

Pharmacy-only benefit items are excluded from the UPN requirement and should continue to be billed on the *Pharmacy Claim Form* (30-1) with the current coding requirements, or using the NCPDP Version D.0/1.2 batch standard. These items include:

- Diabetic testing supplies (test strips and lancets)
- Insulin syringes
- Peak flow meters and inhaler, assist devices
- Condoms
- Diaphragms and cervical caps
- Heparin and normal saline flush solutions
- Enteral nutritional formula

HCPCS and UPN Coding Requirements

HCPCS Level II codes do not require the use of modifiers. Using modifiers can result in denials. However, claims for all <u>contracted</u> HCPCS Level II codes must include a UPN.

- The UPN is the unique product identification number assigned to the product by the manufacturer.
- UPNs facilitate accurate reimbursement of the contracted products.
- UPNs and the products billed must be an exact match to those found in the provider manual

UPN Product Example

Sometimes a manufacturer has two UPNs for the same product, but only the UPN listed for the product is eligible for reimbursement.

- The UPN for the product dispensed must be the exact UPN billed.
- A provider <u>may not</u> purchase a product and dispense it to a Medi-Cal beneficiary using a UPN that is not listed in the manual and bill Medi-Cal for the listed UPN. This would be considered fraud, and would subject the provider to a possible audit.

Billing for Contracted Products

The provider manual lists the contracted incontinence and medical supply products with the appropriate HCPCS Level II codes, UPNs required for billing and the reimbursement amount.

Supplemental pricing information (catalog page, price list or invoice) is not required as an attachment to the claim for contracted items.

Providers must use the HCPCS Level II codes with UPNs on claims exactly as they are listed in the provider manual to ensure correct reimbursement.

Contracted Product Information in the Provider Manual

Information on contracted products can be found by following the links in the *Medical Supplies* (mc sup) section of the Part 2 provider manual.

List of Contracted Advanced Wound Care Dressings (excerpt)

List of Contracted Wound Care Advanced Dressings

This spreadsheet contains wound care advanced dressings eligible for reimbursement when billing for the contracted wound care HCPCS billing codes for Medi-Cal fee-for-service outpatient recipients. The products' Universal Product Number (UPN) and UPN Qualifier must be included on the claim as published on this spreadsheet. **The UPN on the claim must be an exact match for the product dispensed**. Refer to the *Medical Supplies: Billing Codes, Units and Quantity Limits spreadsheet* for the billing codes, quantity limits and non-contracted wound care HCPCS billing codes. Refer to the *Medical Supplies* section of the provider manual for additional coverage and billing information. This spreadsheet is subject to change with notification in the provider bulletins. Product updates or additions to the spreadsheet will be **bolded**. Product deletions from the spreadsheet will have ~~strikethroughs~~. 'MAC' refers to the maximum acquisition cost guaranteed by the manufacturer, upon request, for dispensing to eligible Medi-Cal fee-for-service recipients. 'MAPC' refers to the maximum allowable product cost reimbursed. 'UOM' refers to the unit of measure.

Billing Code (HCPC	Manufacturer	Product Description	Item Number (referenc	UPN Qualifier	UPN	MAC and MAPC per U	UOM	Effective Date of Chan	Publication Date
A6207	Coloplast	Physiotulle Contact Layer 4" x 8" Box/3	3912	EN	5708932538879	$11.82	ea	4/1/2017	February 2017
A6207	Coloplast	Physiotulle Contact Layer 4" x 8" Case/300	3912	EN	5708932538886	$11.82	ea	4/1/2017	February 2017
A6207	Coloplast	Physiotulle Contact Layer 4" x 8" Each	3912	EN	5708932538862	$11.82	ea	4/1/2017	February 2017
A6207	Coloplast	Physiotulle Contact Layer 6" x 6" Box/17	3920	EN	5708932538909	$11.82	ea	4/1/2017	February 2017
A6207	Coloplast	Physiotulle Contact Layer 6" x 6" Case/170	3920	EN	5708932538916	$11.82	ea	4/1/2017	February 2017
A6207	Coloplast	Physiotulle Contact Layer 6" x 6" Each	3920	EN	5708932538893	$11.82	ea	4/1/2017	February 2017
A6207	Coloplast	Physiotulle Contact Layer 6" x 8" Box/17	3915	EN	5708932538848	$11.82	ea	4/1/2017	February 2017
A6207	Coloplast	Physiotulle Contact Layer 6" x 8" Case/170	3915	EN	5708932538855	$11.82	ea	4/1/2017	February 2017
A6207	Coloplast	Physiotulle Contact Layer 6" x 8" Each	3915	EN	5708932538831	$11.82	ea	4/1/2017	February 2017
A6207	Crawford Hlthcare	KerraContact Ag 4" x 5" Box/10	PN-09-0103	EN	5060077231924	$11.82	ea	4/1/2017	February 2017
A6207	Crawford Hlthcare	KerraContact Ag 4" x 8" Box/10	PN-09-0104	EN	5060077231948	$11.82	ea	4/1/2017	February 2017
A6207	Crawford Hlthcare	KerraContact Ag 6" x 6" Box/10	PN-09-0105	EN	5060077231962	$11.82	ea	4/1/2017	February 2017
A6207	Hollister	Restore contact layer Flex 4" x 5" Each	506488	UP	813303010306	~~$44.54~~ $11.82	ea	4/1/2017	February 2017
A6207	Hollister	Restore contact layer Flex 6" x 8" Each	506489	UP	813303010313	~~$44.54~~ $11.82	ea	4/1/2017	February 2017
A6207	Medline	Versatel contact layer 4" x 7"	MSC1747EP	UK	10884389151006	~~$11.94~~ $11.82	ea	4/1/2017	February 2017

Billing for Non-Contracted Products

Claims for non-contracted medical supplies require only a HCPCS Level II code. Do not include a UPN or description of the product. The product dispensed must meet the description of the non-contracted HCPCS code billed. Supplemental pricing information (catalog page, price list or invoice) is required for HCPCS codes that do not have a price on the formulary file. HCPCS codes that have a price on the formulary file do not require supplemental pricing Information.

The List of Medical Supplies: Billing Codes, Units and Quantity Limits spreadsheet link in the *Medical Supplies* (mc sup) section of the provider manual indicates which HCPCS Level II codes have a price on the formulary file, under the MAPC (Maximum Allowable Product Cost) column in the spreadsheet.

When entering a description in the shaded area of box 24D, the information must match the description found on the attachment for a claim that does not require a UPN. If the descriptions on the claim and on the attachment do not match, the claim will be denied.

Note: HCPCS Level II codes do not require the use of modifiers. Use of modifiers can result in denials.

Non-Contracted Product Information in the Provider Manual

See the List of Medical Supplies: Billing Codes, Units and Quantity Limits link in the *Medical Supplies* (mc sup) section of the Part 2 provider manual for a spreadsheet of non-contracted HCPCS billing codes and for information on non-contracted wound care products.

Medical Supplies Billing Codes, Units and Quantity Limits (excerpt)

Medical Supplies Billing Codes, Units and Quantity Limits

This spreadsheet contains medical supply billing codes, unit of measure (UOM) and quantity limits. Refer to the *Medical Supplies* section of the provider manual for additional information and program coverage. Refer to the appropriate spreadsheet for billing codes restricted to contracted products. Certain medical supplies must be billed by a pharmacy provider only using the product's 11-digit Universal Product Number (UPN). This List is subject to change with notification in the provider bulletins. Updates or additions to the List will be **bolded**. Deletions will have ~~strikethroughs~~. 'MAPC' refers to the maximum allowable product cost reimbursed.

Billing Code (HCPCS)	Restricted to Contracted Products (Y/N)	Description	MAPC per Unit of Measure (UOM)	UOM	TAR Required (Y/N)	Quantity Limits Without Authorization	Billing Notes	Effective Date of Change	Publication Date
A4206	N	Syringe with needle, sterile, 1 ml or less,	By Report	ea	N	200 per 27-day period		Prior to 2/16/2015	February 2015
A4207	N	Syringe with needle, sterile 2 ml	By Report	ea	N	200 per 27-day period		Prior to 2/16/2015	February 2015
A4208	N	Syringe with needle, sterile 3 ml	By Report	ea	N	200 per 27-day period		Prior to 2/16/2015	February 2015
A4209	N	Syringe with needle, sterile 5 ml or greater	By Report	ea	N	200 per 27-day period		Prior to 2/16/2015	February 2015
A4212	N	Non-coring needle	By Report	ea	N	6 per 27-day period		Prior to 2/16/2015	February 2015
A4213	N	Syringe, bulb type (infant nasal aspiraters, ear and ulcer bulb syringes)	By Report	ea	N	one per 365-day period		Prior to 2/16/2015	February 2015
A4215	N	Needle, sterile, any size, each	By Report	ea	N	100 per 27-day period		Prior to 2/16/2015	February 2015
A4223	N	Intravenous administration set (with or without infusion pump), hypodermoclysis administration set, connecting device, heparin lock caps	By Report	ea	N	30 per 27-day period		Prior to 2/16/2015	February 2015

Claim Formats

Electronic Claim Format

For electronic claims, medical supply products must be billed with HCPCS Level II codes using the ASC X12N 837P 5010 format. Companion guides for the ASC X12N 837P 5010 format are available on the Medi-Cal website and include information regarding the placement of UPNs.

Excluded items must continue to be billed using the NCPDP Batch D.0/1.2 claim format:

- Diabetic testing supplies (test strips and lancets)
- Insulin syringes
- Peak flow meters and inhaler, assist devices
- Condoms
- Diaphragms and cervical caps
- Heparin and normal saline flush solutions
- Enteral nutritional formula

For electronic attachment submissions, the Attachment Control Number (ACN) form will be supplied to the provider by the vendor and must be entered in the ASC X12N 837 v.5010 Paperwork (PWK) Segments. For more information, refer to the provider manual.

Paper Claim Format

For paper claims, medical supply products billed with HCPCS Level II codes must be billed using the *CMS-1500* claim form. Instructions for completing the *CMS-1500* claim form and placement of UPNs are available on the Medi-Cal website.

Items excluded for billing on the *CMS-1500* claim form include:

- Diabetic testing supplies (test strips and lancets)
- Insulin syringes
- Peak flow meters and inhaler, assist devices
- Condoms
- Diaphragms and cervical caps
- Heparin and normal saline flush solutions
- Enteral nutritional formula

HCPCS Level II codes cannot be billed on the *Pharmacy Claim Form* (30-1).

UPN Placement of UPN Product Qualifiers

UPNs require that a UPN product qualifier be entered in front of the UPN in the shaded area of box 24A of the *CMS-1500* claim form. The product's UPN qualifier is listed with the product's UPN in the provider manual pages for each category of medical supplies and incontinence supplies. The claim must include the product's UPN and UPN qualifier as published in the provider manual. The UPN qualifiers listed can be any of the following:

- **EN** – Global Trade Item Number (GTIN) European Article Number
- **(EAN)/UCC** – 13-digit numbers
- **EO –** GTIN EAN/UCC – 8-digit numbers
- **HI** – Health Care Industry Bar Code (HIBC)
- **ON** – Customer Order Number
- **UK** – GTIN EAN/UCC – 14-digit numbers
- **UP** – GTIN UCC – 12-digit numbers (U.P.C.)

UPNs are up to 19 digits in length.

UPN Qualifier and UPN Placement: CMS-1500 Claim Form

Enter the UPN qualifier (EN, EO, HI, ON, UK or UP) followed by the UPN listed in the provider manual in the shaded area of Box 24A on the *CMS-1500* claim form, left justified:

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
1	UK12345678901234									
2										
3										

UPN Placement of Unit of Measure Qualifiers

UPNs require a unit of measure qualifier for the size or per-unit quantity. These qualifiers are available in the provider manual for each category of medical supplies and incontinence supplies. Valid unit of measure qualifiers include:

- **F2** = International unit
- **GR** = Gram
- **ML** = Milliliter
- **UN** = Unit (inch, yard, each, etc.) – used for most medical and incontinence supplies

Zero-fills are used to enter the quantity in a 10-digit format in the shaded area in box 24D of the *CMS-1500* claim form.

- The first 7 digits represent the whole number (with leading zeroes)
- The last 3 digits represent the fraction (with ending zeroes)

The quantity in box 24G must match the quantity in the shaded area of 24D.

- 2 grams is listed as: GR0000002000
- 240 milliliters is listed as: ML0000240000

UPN Placement of Unit of Measure Qualifiers: CMS-1500 Claim Form

Enter the unit of measure qualifier (F2, GR, ML or UN) and 10-digit quantity (7-digit whole number plus 3-digit decimal) in the shaded area of Box 24D, left justified:

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
1									UN0000030000	
2										
3										

***CMS-1500* claim form example (excerpt) with appropriate UPN placement**

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.
1	UK10610075077233								UN0000002000						
	04	15	18				12		A4399			23 00	2		NPI
2	ON30003175507								UN0000002000						
	04	15	18				12		A4367			15 00	2		NPI
3	UP762123001493								UN0000006000						
	04	15	18				12		A4363			14 00	6		NPI
4	EN0762123010327								UN0000030000						
	04	15	18				12		A4362			95 00	30		NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ 147 00 | 29. AMOUNT PAID $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED Jane Doe DATE 04/15/18

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
JANE SMITH
1027 MAIN STREET
ANYTOWN, CA 958235555
a. 0123456789 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197

Reimbursement

Providers must include the mark-up and tax (if applicable) for total reimbursement in box 24F of the *CMS-1500* claim form. Providers must not exceed the upper billing limit (no more than 100 percent above cost or usual and customary charge) for incontinence and medical supplies:

Medi-Cal will pay the lesser of the:

- Billed amount
- Price on the formulary file
- Price on catalog page, price list or invoice

Medical supplies are reimbursed at maximum allowable product cost (MAPC) plus 23 percent mark-up and tax (if applicable). Incontinence supplies are reimbursed at MAPC plus 38 percent mark-up and tax (if applicable). See the Part 2 provider manual for a list of taxable and non-taxable HCPCS Level II codes. See Guidelines A at the end of this module for catalog, price list and invoice criteria requirements as an attachment for reimbursement of claims.

Billing Tips

Billing Tips for Service Code Groupings (SCGs)

Service Code Groupings (SCGs) can be used to bill quantities and frequencies up to Medi-Cal limits. Quantities and frequencies that exceed Medi-Cal limits must be requested by the provider separately on a product-specific Service Authorization Request (SAR).

Details regarding quantity and frequency limits can be found in the Medi-Cal provider manual.

Billing Tips for TARs and SARs

- Refer to the provider manual for HCPCS Level II codes.
- Providers with a *Treatment Authorization Request* (TAR)/Service Authorization Request (SAR) for products approved under the wrong procedure code will be denied with RAD code 0225: "This is an incorrect procedure code and/or modifier for this service. Please resubmit."
- Product descriptions on the TAR/SAR must match the item description found on the catalog page, price list or invoice attached to the claim for reimbursement.
- See Guidelines B and C at the end of this module for additional tips from the TAR field office for TAR approval.

- Quantity unit requests on TARs must be billed in accordance to TAR guidelines for the type of TAR (medical or pharmacy) approved:
  - 180 total approved medical TAR units would equal 6 months times 30 units each month (6 x 30 = 180).
  - The provider would bill 30 units or less each month and the TAR would be reduced accordingly by 30 units or less each billing until the total units were depleted.
  - Six (6) total approved pharmacy TAR units would equal 30 per month for a period of 6 months. The TAR would be reduced by 1 each month until the total units are depleted.
  - Since Medical and Pharmacy TARs employ different unit quantities, providers must be sure to bill for the correct units based on the type of TAR (medical or pharmacy) being submitted.
  - When billing for incontinence products without a TAR or SAR, the quantity billed must not exceed the quantity limits listed in the "Incontinence Medical Supplies Billing Codes" table in the *Incontinence Medical Supplies* (incont) section of the Part 2 provider manual. When billing for incontinence medical supplies that require an approved TAR or SAR, the quantity billed must not exceed a one-month supply (the total quantity approved divided by the number of months approved) in a 27-day period. This billing requirement also applies to claims with a TAR or SAR to exceed the $165 per-month limit for incontinence products.

Additional Billing Tips

Procedure codes and products to be billed per guidance from DHCS:

- A4212 – Huber needles
- A4215 – Pen needles
- A4223 – I.V. sets, connecting device, heparin lock caps. Does not include I.V. prep wipes, transparent dressings, I.V. start kits, etc. Refer to the provider manual for correct billing codes.
- A4322 – Irrigation syringe, regardless of how used (for example, used for feeding or irrigation 50 ml and over, common size 60 ml) when billing attachment does not describe the item otherwise.
- A4628 – Yankauers
- A9274 – Omni Pods, effective for dates of service (DOS) on or after September 1, 2018, refer to the DME provider manual for billing policy.
- B9999 – Empty I.V. bags, I.V. catheters, PICC supplies
- J7131 – Hypertonic saline solution, 1 ml (TAR required). Submit TARs to the TAR Processing Center.
- T5999 – Decompression tubes, Peristeen Anal Irrigation

Invoice attachments submitted with claims for medical supplies without all of the required data elements will be denied. Invoices containing insufficient pricing documentation will also be denied. Invoice and catalog page or price list requirements can be found in the *Medical Supplies: Billing Examples* (mc sup ex) section of the Part 2 provider manual.

For electronic claims, when entering additional information in box 19, only 80 bytes will be accepted. Claims of 81 bytes or more will be rejected.

Providers are required to include the certification statement below written exactly as shown for all invoice attachments. The item claimed must be clearly identified on the invoice if the item number is not identified on the statement. A separate certification statement is required for each individual item being billed on an invoice.

> "I certify that I have properly disclosed and appropriately reflected a discount or other reduction in price obtained from a manufacturer or wholesaler in the costs claimed or charges on this invoice identified by item number ________________ as stated in 42 U.S.C. 1320a-7b(b)(3)(A) of the Social Security Act and this charge does not exceed the upper billing limit as established in the *California Code of Regulations* (CCR), Title 22, Section 51008.1 (a)(2)(D)."

Note: The item number is required and must be the product number on the invoice or claim line number. Additionally, the certification statement may be typed, printed or stamped onto the invoice, or otherwise attached to the claim.

Providers can check HCPCS codes on the Medi-Cal website for current status under "Transaction/PTN/Medical Supply" to verify the codes are billable for the requested date of service. See Guidelines D and "Medical Supplies Common Denials" later in this module for additional tips to avoid denied claims.

Guidelines A: TARs for Incontinence and Medical Supplies

Billing using HCPCS Level II procedure codes with no price on the formulary file requires pricing attachments.

Catalog/Price List Reimbursement

- Catalogs/price lists cannot be dated more than five (5) years before or after DOS
- Attachments must include the type of pricing in the title of document (dealer, wholesale, or distributor)
- Attachments must include one or more of the following types of pricing
  - AWP – Average Wholesale Price (If AWP is listed must also include1 additional type of pricing)
  - SWP – Suggested Wholesale Price
  - SWR – Suggested Wholesale Resale
  - Unit Price
  - Net Price
  - Quantity Discount
  - Case Price
- The front cover of catalog/price list must accompany the page if the individual page does not contain type of catalog pricing or date.

Invoice Reimbursement

- Invoices cannot be dated more than one (1) year prior to DOS, and cannot be dated after DOS.
- The following information must be included:
  - Manufacturer/distributor name and address
  - Sold-to/bill-to name and address
  - Invoice number and date
  - Quantity/shipping units purchased (box, case, each). Medi-Cal reimburses medical supplies per the one-each cost.
  - Item/UPN
  - Description of item
  - Unit price (including any discounts)
  - Certification statement, if a discount has been given to the provider

Reimbursement Calculation Formula

When no price is on the formulary file, medical supplies are reimbursed using attachments as described above, and by using the following formulas:

Medical Supplies *

1-each (or gram, milliliter, etc.) cost x quantity x tax rate (if applicable) x 23 percent mark-up.

Incontinence Supplies *

1-each (or gram, milliliter, etc.) cost x quantity x tax rate (if applicable) x 38 percent mark-up.

When AWP, SWP or SWR pricing is used for pricing, the calculation is reduced by 5 percent.

Billing Using HCPCS Level II Procedure Codes:No UPN Required

- If a price is listed on the formulary file, the system will price the claim using the above formulas
- If a price is not on the formulary file, the provider must attach a catalog page, price list or invoice for reimbursement. Claims will be processed using the formulas described in the “Reimbursement Calculation Formula” section above.

Billing Using HCPCS Level II Procedure Codes:Contracted, UPN Required

- The provider must include the published contracted UPN on the claim in the appropriate section.
- The examiner will reimburse the UPN per the contracted one-each price described in the “Reimbursement Calculation formula” section above.

Guidelines B: TARs for Incontinence Supplies from the TAR Field Office

- Any manufacturer's product that meets the description of the non-contracted HCPCS codes is eligible for reimbursement.
- Claims for "By Report" non-contracted HCPCS codes must include documentation of product cost (invoice, manufacturer catalog page or price list) as an attachment to the claim.
- Claims for non-contracted HCPCS codes with an MAPC do not require documentation of product cost (invoice, manufactured catalog page or price list) as an attachment to the claim.

Table of HCPCS Codes Description for Non-Contracted Supplies

HCPCS Code	Description (Non-Contracted Supplies)
A4520	Incontinence garment, any type, each, not elsewhere classified. As of July 1, 2017, the HCPCS code will no longer be reimbursable as a Medi-Cal benefit.
T4529	Pediatric sized disposable brief/diaper, small/medium size, each
T4530	Pediatric sized disposable brief/diaper, large size, each
T4531	Pediatric sized disposable protective underwear/pull-on, small/medium size, each
T4532	Pediatric sized disposable protective underwear/pull-on, large size, each
T4534	Youth sized disposable protective underwear/pull-on (approved for weights up to 80 pounds)
T4543	Disposable brief/diaper, adult size bariatric or triple extra large (XXXL) and above
T4544	Disposable protective underwear/pull-on, adult size triple extra large (XXXL) and above *Effective April 1, 2015

- For clients at home or in board and care, submit a TAR only for costs that go over the $165.00/month allowance and/or over the utilization limits for incontinence supplies. Do not submit a TAR for total amounts used. For billing issues, please call the Telephone Service Center (TSC) at 1-800-541-5555.
- For pediatric sized diapers, height and weight are needed for justification. For XXXL adult sized diapers or larger, height, weight and waist circumference are needed for justification.

- For beneficiaries in an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) or Intermediate Care Facility for the Developmentally Disabled/Nursing (ICF/DD-N), mattress covers and gloves are not to be included on a TAR for incontinence supplies. These are medical supply items.
- A TAR, along with specific medical justification and documentation, is needed to support products that meet the description of a non-contracted incontinence HCPCS code for amounts that exceed the utilization limits. For example, toilet training progress reports, bladder/bowel assessments, incontinent flow records or client care flow records. The medical diagnosis must be related to bowel/bladder incontinence.
- TARs for patients in ICF/DD-H or ICF/DD-N homes are usually authorized for one year or up to the expiration date on the prescription.
- TARs for pediatric-sized diapers over the quantity limit are approved for six (6) months if the child is close to 40 pounds. Children 40 pounds and over must use diapers on the contract list. Non-contracted products may be used for children weighing less than 40 pounds.
- Protective underwear/pull-ons are included on the contracted list for patients over 80 pounds. Direct-bill this item for patients living at home or in board and care. TARs are required when the utilization limit is exceeded, along with medical justification, to be eligible for the $165 per-month allowance.
- TARs may be approved for over-utilization limits with medical justification or documentation to support. For example: "Patient is bedbound, taking medication resulting in increased urine output, chronic diarrhea, G-tube feeds."
- Prescription is only good for a period of 1 year from when it is signed and dated by the physician or when there is an authorization period indicated.
- Residents in an ICF/DD-H or ICF/DD-N are exempt from the optional benefits exclusion criteria. The provider can submit a TAR and request the full unit amount. Approval for the full unit amount will be based on medical necessity. The provider cannot bill direct for patients residing in an ICF/DD-H or ICF/DD-N.
- Medi-Cal does not reimburse for incontinence supplies for recipients younger than 5 years of age. Medi-Cal may reimburse for incontinence supplies through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services benefit in cases where the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, and at an age when the child would normally be expected to achieve continence.
- Provider must indicate "EPSDT supplemental services" under Special Handling.

- Approval is for the full unit amount if the patient is under 5 years of age and in the EPSDT benefit. Medi-Cal may reimburse for incontinence supplies through EPSDT benefits when the incontinence is due to a chronic physical or mental condition.
- For patients 5 years of age or older, but under 21 years of age, the use of contracted HCPCS billing codes must follow the direct billing limitations.
- TARs with multiple requests for contracted products will be deferred, requesting the list of items that are being direct-billed. When completing the TAR, request the number of supply units exceeding the limit multiplied by the number of months requested. Enter this number in the “Quantity” box on the TAR form. Providers must show the calculation on the TAR form for each requested supply that exceeds $165 per recipient, per month.
- The $165 direct-bill amount is for the total accumulation amount for all the items listed on one TAR. The provider must indicate which items have been direct-billed. For the calculation process: Add up the monthly amount, subtract the $165, and divide by the number of items listed. This amount is used to approve the overage amount.
  - Example: One TAR for diapers, underpads and liners. The monthly amount for all 3 items is $265.20. $265.20 – $165 = $100.20. $100.20 divided by 3 products = $33 approved for each product. Divide the monthly cost by the amount per month to get the daily cost amount.
- TARS with “exceeded billing limitations” notations will be reviewed for products for which the provider has already direct-billed. The provider must make this notation on the TAR. If not, the TAR will be deferred for a specific explanation of the product and the amount that was direct-billed.
- When a TAR is received requesting approval to provide an item or service that can be directly billed, and a TAR is not required, the TAR line will be denied and a statement written in the “External Comment” area. Example: “Comments: ‘This service does not require a TAR and may be billed direct. Provider: do not reference the TAR number when billing for TAR free procedures.’”
- TAR requests that indicate the patients are residing in ICF/DD-H or ICF/DD-N homes or have EPSDT services can be adjudicated for up to 12 months or until the prescription expires.

- Prescriptions that have "authorization period" included will be approved. For example if the prescription was signed and dated by the physician as of 7/15/14, the physician has signed an authorization period from 08/28/14 to 08/28/15, and the provider is requesting for these dates of service, the TAR may be approved from 08/28/14 to 08/27/15. If the provider's date of service TAR request is to start 07/16/15, and the physician signed and dated the prescription 07/15/15 for an authorization period from 08/28/14 to 08/28/15, the TAR will be modified and approved for dates from 07/16/15 to 08/27/15. The prescription expires the day before the last authorized date.
- For TARs with incontinence supplies consisting of creams and washes, please ensure the correct units are converted to milliliters and grams.
  - Example:

    Washes: 960 ml per bottle

    Creams: 540 grams, weight may vary

    Provider is requesting for 2 bottles of wash for 12 months. The units on the TAR should be: 960 x 2= 1,920 x 12 months = 23,040 units.

    For one (1) tube of cream at 540 grams: 540 grams x 12 months = 6,480 grams, or units.

Guidelines C: TARs for Medical Supplies from the TAR Field Office

Gloves

Direct-bill for a maximum of 200. A TAR is required for additional requests, with maximum of 100 per TAR, per month.

Wipes

This is a covered benefit only with medical justification.

- If for convenience, it is not covered.
- They are not incontinence supplies.
- No direct billing. TARs must be submitted and approved based on medical necessity justification (such as history of AIDS).
- Code T5999 is used to bill for wipes.

New Prescriptions

A recipient's need for the supply must be reviewed by a physician annually. The prescription must be dated within 12 months of the date of service on the claim. When a prescription expires, a new one, written by a physician, must be requested for billing.

Medicare Coverage for Medical Supplies

When Medicare covers an item and the recipient is eligible for Medicare, provider bills Medicare before billing Medi-Cal. For certain product types (e.g., wound care and infusion supplies), provider may bill Medi-Cal directly only if dispensed for a Medicare non-covered treatment. Medicare coverage for medical supplies can be found in the *Medical Supplies* (mc sup) section of the provider manual.

Medicare EOB Denials and OHC Denials

Medicare Explanation of Benefits (EOB) denials and Other Health Coverage (OHC) denials are submitted with every claim. These TARs are adjudicated based on medical necessity.

Submission and Reimbursement: Miscellaneous

- Providers will be reimbursed based on the price on file for non-contracted items.
- Providers are to submit manufacturer's information with the cost price if the requested item/code does not have a listed price on file.
- Providers submitting service codes using miscellaneous codes, such as S8189 and T5999, must submit a manufacturer catalog page, manufacturer information with UPN, product number or invoice statements.

Electronic TARs (eTARs) and Keyed Data (Paper) TARs

For eTARs and keyed data (paper) TARs, the quantity per month should equal the units requested (for example, for a provider requesting 30 catheters per month, quantity is 30/month, length of time is 6 months, units is 180). Providers can direct-bill for products without prior authorization as described in the provider manual and on the Medi-Cal website. Items for direct billing should not be included in the quantity per month.

Nipple feeders

Nipple feeders are medical supply items. Service code T5999 must be used. The provider must submit a CCS denial letter. Adjudication is based on medical necessity. Haberman feeders are Durable Medical Equipment (DME) items billed using code S8265.

Self-Reinflating Resuscitator bags

TARs for self-reinflating resuscitator bags should be sent to the West Sacramento TAR Processing Center.

Blood pressure apparatus

Blood pressure machines are not medical supply items and must be billed as a DME item. TARs for blood pressure apparatus should be sent to the West Sacramento TAR Processing Center.

Nebulizer machines

Nebulizers are not medical supply items and must be billed as a DME item. TARs for nebulizer machines should be sent to the West Sacramento TAR Processing Center.

HCPCS code A4930

HCPCS code A4930 (gloves, sterile, per pair) is a non-contracted Medi-Cal benefit. A TAR and documentation of product cost (invoice, catalog or price list) is required when billing with code A4930.

Non-sterile disposable gloves

Non-sterile disposable gloves are billed using HCPCS code A4927 (gloves, non-sterile, per 100).

Gauzes

Gauzes are paid per-each gauze, not per-box. Units should be for the total gauzes per time frame (3 months – 6 months).

Example: 400/month of 4x4, direct-bill 200 per month. Patient has 3 wounds. 200 gauzes x 3 wounds = 600 per month. Total amount of 600 gauzes per month (for 3 wounds) for 3 months = 1,800 gauzes. Units: 1,800. Amount per month: 200. Anticipated length of need: 3 months.

Tape

Tape of any kind using HCPCS codes T5999 or S8189 is not a covered benefit supply and is a common household item.

Prescriptions

Prescriptions must be signed and dated by the physician. Acceptable formats include: written and/or electronic signatures only.

Prescriptions that include “authorization period” will be approved. For example: if the prescription was signed and dated by the physician as of 7/28/14, the physician has signed an authorization period from 9/1/14 to 9/1/15, and the provider is requesting for these dates of service, the TAR may be approved from 9/1/14 to 8/31/15. If the provider’s date of service TAR request is to start 7/28/15, and the physician signed and dated the prescription 7/28/15 for an authorization period of 9/1/14 to 9/1/15, the TAR will be modified approved for dates 7/28/15 to 8/31/15. The prescription expires the day before the last authorized date.

Reauthorization requests

Providers must submit a brand new eTAR or keyed entry (paper) TAR for all reauthorization requests. Through dates of service cannot be extended. The TAR will be returned to the provider.

Duplicate TAR requests

Duplicate TAR requests will be denied and include the following comment: "This is a duplicate request of TAR number __________. Please follow the appeal process for the initial TAR that was modified or denied. Submit the documentation along with a completed paper TAR to the TAR Administrative Remedy Section in Sacramento."

Note: If a deferred TAR was auto-denied, the resubmitted TAR should contain the initial requested documentation and the TAR number from the deferred-then-denied TAR.

TARs: Miscellaneous

- A TAR requesting approval for an item or service that can be directly billed, and for which a TAR is not required, will be denied. A statement will be included in the "External Comment" area stating that the provider can directly bill the item or service without authorization if it is within the allowed frequency limit. Field office consultants will use this statement in the "External Comments" area: "This service does not require a TAR and may be direct-billed. Provider: do not reference the TAR number when billing for TAR free procedures." This TAR denial does not apply if the request is for an overage amount.
- When a TAR is received for I.V. care supplies, peripherally inserted central catheter (PICC) line supplies, and/or central line supplies, specific physician's orders are not required. Examples of I.V. supplies that have their own HCPCS procedure codes are: broad-spectrum skin antiseptics, translucent dressings, sterile gloves, gauzes, and betadine wipes.
- If the submitted TAR states "exceeded billing limitations" and the physician's order can be billed directly, the TAR will be deferred for denial information or for a *Remittance Advice Detail* (RAD) to be submitted. TAR requests will be approved or modified for the overage amount of the direct bill HCPCS code.
- TAR requests that indicate the beneficiary is residing in an ICF/DD-H or ICF/DD-N home, or is under 5 years of age and receiving EPSDT services, can be approved for up to 12 months or until the prescription expires. Providers cannot bill directly for these. TARs are approved based on medical necessity. The incontinence supply prescription forms are acceptable formats for approving these TARs.

Guidelines D: 90-Day Frequency Limitations for Medical Supplies

Some providers experience 90-day frequency-limit claim denials for medical supply items such as ostomy, tracheostomy and urological supplies. The following billing scenarios are intended to help providers understand these 90-day frequency limitations and avoid claim denials.

Scenario 1

"Provider A" dispenses a 30-day supply of a medical supply item. On the 27th day after the dispense date, the provider can either:

- Dispense an additional 30-day supply of the same item, or
- Dispense a 60-day supply of the same item. After the 54th day, the provider may dispense the next 60-day supply of the same item.

A denial will not be triggered in this case because the total items dispensed in the previous 84 days by this provider will not exceed the 90-day supply frequency limit.

Scenario 2

"Provider B" dispenses a 60-day supply of a medical supply item. On the 54th day after the dispense date, the provider can dispense an additional 30-day supply of the same item. The provider must now wait 27 or more days to dispense the next supply.

A denial will not be triggered in this case because the total items dispensed in the previous 84 days by the provider will not exceed the 90-day supply frequency limit.

Scenario 3

"Provider C" dispenses a 90-day supply of a medical supply item. On the 81st day after the dispense date, the provider can dispense the next 90-day supply of the same item.

Providers are advised to remember that the date of service (not the date of claim submission) is used to determine frequency limits. When providers follow the above billing practices, they should not receive frequency-limit denials unless a different provider bills for the same item.

For additional information, providers should refer to the following Part 2 provider manual sections: *List of Contracted Intermittent Urinary Catheters* (mc sup urinary), List of Contracted Ostomy Supplies (mc sup ostomy), *List of Contracted Tracheostomy Supplies* (mc sup tracheostomy) and *List of Medical Supplies: Billing Codes, Units and Quantity Limits* (mc sup billing). Providers may also contact the Telephone Service Center (TSC) at 1-800-541-5555.

Medical Supplies Common Denials

Table of RAD Code Description and Billing Tips

RAD Code	Reason RAD Description	Billing Tips
0005	The service billed requires an approved TAR (*Treatment Authorization Request*).	Procedure code requires a TAR. The quantity and frequency limits have been exceeded. Units on TAR have been exhausted.
0010	This service is a duplicate of a previously paid claim.	Check to see if the item is exactly the same as your previous claim. If not, submit an appeal with all documentation attached. When billing the same procedure code for multiple items, include the product information for each item to clarify what you are billing for.
0225	This is an incorrect procedure code and/or modifier code for this service. Please resubmit.	Check provider manual to verify there is not a more specific HCPCS code for the item being billed.
0697	The drug/medical supply dispensed has exceeded the dispensing frequency limitation.	Verify that quantity or frequency limits have not been exceeded. Medi-Cal may have received more than one claim for the procedure code being billed. If the limits have been exceeded an authorization will be required.
9051	Indicate the quantity per box on the invoice.	Need to break down the quantity purchased on the invoice to the one-each price for reimbursement.
9098	The attached documentation is invalid. Refer to RAD code 0353 Billing Tip for additional information.	Attached documentation does not meet the catalog or invoice requirements found in the *Medical Supplies: Billing Examples* section of the Part 2 provider manual, pages 4–7. This denial is also used when your attachment includes one or more errors.
9101	A copy of the manufacturer's catalog page or supplier's invoice is required.	No attachments were received with the claim. Attach a catalog page, price list or invoice to the claim.

Table of RAD Code Description and Billing Tips (continued)

RAD Code	Reason RAD Description	Billing Tips
9104	The attached invoice is illegible. Please resubmit.	Copy is bad. Adjust copy machine to produce a clear copy.
9217	Indicate a line number next to the catalog number.	If multiple line items are being billed or multiple items are listed on the catalog page, price list, or invoice, indicate which item is to be used for reimbursement of each claim line.
9251	The service billed requires a product-specific SAR (Service Authorization Request). Please contact your local CCS (California Children's Services) office.	Provider has exceeded the frequency and/or quantity limits for Medi-Cal. Service grouping SARs cannot be used for items over the limits.
9556	Either the invoice or the certification is missing or invalid.	Verify the certification statement is written exactly as shown in the provider manual. Line number or product number required. Each item billed requires a separate certification statement.
9670	Claim date of service does not match date of service on SAR (Service Authorization Request) file.	Verify span date on SAR authorization with DOS (Date of Service).
9671	Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program).	Verify procedure code being billed is listed on authorization.
9713	The date on the catalog or invoice is missing or invalid.	Date on catalog cannot be older than five (5) years prior to the date of service on the claim. Invoice date cannot be more than one (1) year prior to date of service.

Table of RAD Code Description and Billing Tips (continued)

RAD Code	Reason RAD Description	Billing Tips
9897	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is missing.	HCPCS code requires UPN and qualifier be included on the claim for reimbursement. See the Allied Health provider manual for instructions on correct placement on the CMS-1500 claim form.
9898	HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.	The HCPCS code and/or qualifier is incorrect on the claim form. Verify information in the Allied Health provider manual for correct UPN/qualifier used for billing. Information must match provider manual exactly.

Resource Information

References

Provider Manual References

The following reference materials provide Medi-Cal billing and policy information.

Part 2

Durable Medical Equipment (DME): An Overview (dura)

Incontinence Medical Supplies (incont)

List of Contracted Advanced Wound Care Dressings (mc sup wound)

List of Contracted Diabetic Test Strips and Lancets (mc sup diabetic)

List of Contracted Incontinence Absorbent Products (incont list)

List of Contracted Incontinence Creams and Washes (incont cr list)

List of Contracted Intermittent Urinary Catheters (mc sup urinary)

List of Contracted Ostomy Supplies (mc sup ostomy)

List of Contracted Tracheostomy Supplies (mc sup tracheostomy)

List of Contracted Waterproof Sheeting (mc sup sheeting)

List of Medical Supplies: Billing Codes, Units and Quantity Limits (mc sup billing)

Medical Supplies (mc sup)

Medical Supplies: Billing Examples (mc sup ex)

Other References

Medi-Cal website (*www.medi-cal.ca.gov*)

Medi-Cal bulletins

Medi-Cal Learning Portal: Online Tutorials

Appendix

Acronyms

Acronym	Description
BIC	Benefits Identification Card
CA-MMIS	California Medicaid Management Information System
CCN	Claims Control Number
CCS/GHPP	California Children's Services and Genetically Handicapped Persons Program
CHDP	Child Health and Disability Prevention
CHF	Congestive heart failure
CMC	Centers for Medicare & Medicaid Services
CRTS	Certified Rehabilitation Technology Supplier
CSU	Correspondence Specialist Unit
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
EAC	Estimated Acquisition Cost
FI	Fiscal Intermediary, contractor for DHCS responsible for claims processing
HAP	Health Access Programs
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
ICD-10	International Classification of Diseases – 10th Revision
LPM	Liters Per Minute
LTC	Long Term Care
LSRS	Lab Service Reservation System
MAC	Maximum Allowable Product Cost
MAPC	Maximum Allowable Product Cost
MNIHA	Medicare Necessary Interperiodic Health Assessment

Acronyms Table (continued)

Acronym	Description
MSRP	Manufacturer's Suggested Retail Price
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
NF	Nursing Facility (Level A or B)
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
OT	Occupational Therapist
O&T	Orthotics & Prosthetics
POS	Point of Service
PT	Physical Therapist
RAD	Remittance Advice Details
RESNA	Rehabilitation Engineering and Assistive Technology Society of North America
RHC	Rural Health Clinic
RTIP	Real-Time Internet Pharmacy
SAR	Service Authorization Request
SNF	Skilled Nursing Facility
SOC	Share of Cost
TAR	Treatment Authorization Request
TCN	TAR Control Number
TSC	Telephone Service Center
UPC	Universal Product Code
UPN	Universal Product Number

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