

Redding
 Vacaville Eureka
 Paradise Chico
 Citrus Heights
 Thousand Oaks
 San Francisco
 Seaside
 Ventura
 Carmel
 Humboldt
 Mendocino Marin
 Bishop
 Tahoe City Bieber Eagleville
 Lone
 Folsom
 Elk Grove
 Oxnard
 Solvang
 Santa Barbara
 Fort Bragg
 Visalia
 Huntington Beach
 Victorville Weed
 Barstow Baker
 Adin
 Salinas
 Simi Valley
 San Andreas
 Ontario
 Mojave
 Indio
 Lancaster
 Escondido Orange
 Torrance Hemet
 Garden Grove
Santa Ana
Long Beach
 Vista San Clemente Julian
 Chula Vista Alpine
 San Marcos
 San Diego

Medi-Cal

**Provider
Training
2017**



Child Health and Disability Prevention
 & Durable Medical Equipment



The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP's easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at <http://www.medi-cal.ca.gov/education.asp>.

Free Services for Providers

Provider Seminars and Webinars

Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives

The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit

The four SPBU Specialists are dedicated to providing 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 SPBU 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!

Table of Contents

Child Health and Disability Prevention

| | |
|--------------------------------------|----|
| Introduction..... | 1 |
| CHDP Program..... | 2 |
| CHDP Gateway Policies | 3 |
| CHDP Applications | 5 |
| Federal Requirements | 11 |
| Billing Information | 11 |
| Claim Completion | 15 |
| Claim Submission..... | 24 |
| Resource – Local CHDP Directory..... | 26 |

Durable Medical Equipment

| | |
|---------------------------------------|----|
| Introduction..... | 1 |
| Program Coverage | 2 |
| DME Policies and Clarifications | 2 |
| Billing..... | 7 |
| Equipment | 11 |
| DME Common Denials | 16 |

Appendix

| | |
|----------------|---|
| Acronyms | 1 |
|----------------|---|

Child Health and Disability Prevention

Introduction

Purpose

The purpose of this module is to provide an overview of the Child Health and Disability Prevention (CHDP) program Gateway pre-enrollment process, claim completion for the *Confidential Screening/Billing Report (PM 160)* form and CHDP billing tips.

Module Objectives

- Discuss the basics of the CHDP Gateway
- Understand the eligibility requirements for the CHDP Gateway, including Infant Deemed Eligibility
- Review the *Child Health and Disability Prevention (CHDP) Program Pre-Enrollment Application (DHCS 4073, revised 10/13)*
- Explain the standard and information-only *Confidential Screening/Billing Report (PM 160)* form
- Identify useful billing tips to prevent common CHDP billing errors

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

CHDP Provider Manual References

Appendix: CHDP Program Pre-Enrollment Application (DHCS 4073) (form)

Child Health and Disability Prevention (CHDP) Program: Billing and Reimbursement (child health bil)

Confidential Screening/Billing Report (PM 160) Claim Form: Completion Instructions (conf clm comp)

Confidential Screening/Billing Report (PM160) Claim Form: Completion Instructions for Labs (conf clm comp lab)

Eligibility: CHDP Services (elig chdp)

Rates: Maximum Reimbursement for CHDP (rates max chdp)

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (rural)

Other References

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

CHDP Program

The Child Health and Disability Prevention (CHDP) program began in 1973 and provides services to children and youth under 21 years of age based on a periodicity schedule. CHDP provides _____ that include complete physical exams, vision and hearing screenings, immunizations, lab screenings and anticipatory guidance.

Gateway

The CHDP Gateway is a process to maximize the enrollment of uninsured children into comprehensive health care services (for example, Medi-Cal). Only _____ providers may participate in the CHDP Gateway enrollment process. To find out more about becoming a CHDP provider, contact your local CHDP office. A CHDP county directory is located at the end of this module and also on the CHDP website via the “Contact a CHDP Program” link at (www.dhcs.ca.gov/services/chdp).

Families for which Share of Cost (SOC) has not been obligated for the month of service may receive full-scope Medi-Cal benefits beginning on the day PE determination is made. Coverage may continue to the last day of the following month upon completion of a DHCS 4073 form and submission of a Gateway transaction.

Families for which an SOC has already been obligated for the month of service may receive full-scope Medi-Cal for the subsequent month upon completion of a DHCS 4073 form and submission of a Gateway transaction.

An immediate eligibility response is provided at the time of the CHDP Gateway transaction. During the application process, a Medi-Cal application can be requested to continue coverage after the pre-enrollment period ends. An overview of the CHDP Gateway enrollment process is located in the *Gateway* section (gate) of the CHDP provider manual.

CHDP Gateway Policies

Eligibility

To start the enrollment process, the parent, legal guardian or emancipated minor completes the required information on the *CHDP Program Pre-Enrollment Application* (DHCS 4073), which can be downloaded and printed from the CHDP website.

To be eligible for pre-enrollment using the CHDP Gateway, the child/youth must:

- Be younger than 19 years of age
- Have a family income at or below 266 percent of the Federal Income Guidelines (Refer to the “Federal Income Guidelines” on the following page.)
- Be a California resident

Infant Enrollment

The CHDP Gateway process allows automatic enrollment into Medi-Cal for eligible infants younger than _____ of age without their parent or parents having to complete an Application for Health Insurance. The CHDP Gateway transaction may enroll eligible infants into full-scope, no-cost Medi-Cal coverage until their first birthday.

Information provided on the DHCS 4073 links the infant with the mother whose delivery was covered under Medi-Cal. For automatic infant enrollment, fields on the DHCS 4073 require the following:

1. _____
2. _____

An infant enrollment flyer explaining this process is available in English and Spanish for parents of infants younger than 1 year of age. The provider’s office should give this flyer, along with the DHCS 4073, to families of infants younger than 1 year of age who have no other health insurance coverage at the time of a CHDP health assessment.

Answer Key: 1 month; 1) The mother’s date of birth; 2) The mother’s Medi-Cal ID number

Income Eligibility

Eligibility for CHDP services is based, in part, on family size and income. The following chart is used to determine whether a CHDP applicant's gross family income is at or below the program income limits. "Gross income" refers to income before taxes and other deductions. This chart is updated annually.

| INCOME ELIGIBILITY GUIDELINES 266 Percent of the 2016 Federal Poverty Guidelines Effective January 1, 2016, through December 31, 2016 (For determinations of CHDP Gateway aid codes 8W and 8X only) | | |
|--|-----------------------|----------------------|
| Number of Persons in the Household | Monthly Income | Annual Income |
| 1 | \$2,634 | \$31,601 |
| 2 | \$3,552 | \$42,614 |
| 3 | \$4,469 | \$53,626 |
| 4 | \$5,387 | \$64,638 |
| 5 | \$6,305 | \$75,651 |
| 6 | \$7,222 | \$86,663 |
| 7 | \$8,142 | \$97,702 |
| 8 | \$9,064 | \$108,768 |
| 9 | \$9,987 | \$119,833 |
| 10 | \$10,909 | \$130,899 |
| For each additional person, add: | \$923 | \$11,066 |

NOTE

If the child/youth is not eligible because his/her family's income does not meet the federal income guidelines, give the parent, legal guardian or emancipated minor an Application for Health Insurance, or have them call toll free 1-800-300-1506, Monday through Friday 8 a.m. to 6 p.m. or Saturday 8 a.m. to 5 p.m., to request an application.

CHDP Applications

Pre-Enrollment

If the child/youth does not have a way to pay for the health exam, a DHCS 4073 should be given to the parent, legal guardian or emancipated minor to complete.

The DHCS 4073 may be downloaded by CHDP providers from the CHDP website (www.dhcs.ca.gov/services/chdp). Under “Local CHDP Programs” click “Forms”, scroll down to “Pre-Enrollment Application – DHCS 4073” and select the appropriate language. Enter the information from the DHCS 4073 application into the CHDP Gateway Internet or via the Health Enterprise (HE) Portal or the Point of Service (POS) device.

NOTE

If the child/youth is not found in the DHCS database to be already eligible for services during the month of the visit, the individual’s pre-enrollment into the CHDP Gateway will be established as long as the age, income and residency requirements are met.

Certification

The parent, legal guardian or emancipated minor who completed the DHCS 4073 application must sign the document prior to the submission of a Gateway transaction. The application is not complete without the signature.

Billing Tip: Providers must perform an eligibility transaction after the Gateway pre-enrollment transaction to confirm the patient’s eligibility.

Brainteaser

1. If incorrect information has been submitted with the successful Gateway pre-enrollment transaction, providers may submit another Gateway transaction to correct the information.

True False

Important: If any errors are detected after the Gateway transaction has been completed, do not submit another application in an attempt to make corrections. This could create duplicate records. Instead, report the problem to your local Social Services Agency – Eligibility Worker. Errors may be corrected if the family completes the Application for Health Insurance.

2. The original signed DHCS 4073 application must be _____.

Answer Key: 1) False; 2) Retained in the child’s/youth’s file

6 Child Health and Disability Prevention

State of California—Health and Human Services Agency

Department of Health Care Services
Children's Medical Services Branch

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM PRE-ENROLLMENT APPLICATION

Instructions to the Parent or Patient:

- In order to receive a health examination today at no charge, you must provide the information required on this form. The information you give is confidential. This is a voluntary program.

Is the patient less than 19 years of age? Yes No

How many people are in your family? _____

How much money does your family make before taxes? \$ _____ Or \$ _____
Monthly Yearly

- You or your child may be eligible for continued health care coverage through Medi-Cal or premium assistance programs under Covered California.

I want to apply for continued coverage through Medi-Cal or premium assistance programs under Covered California. Yes No

If you answered *yes* to this question, an application will be mailed to you in a few days. Please return it promptly. If you answered *no* to this question (or if you answered *yes* but do not return the application), the patient's coverage for health, dental, and vision benefits will stop at the end of next month unless the county Department of Social Services notifies you otherwise.

Patient Information

Does the patient have a State of California Benefits Identification Card (BIC) or Medi-Cal card? Yes No

If yes, what is the identification number on the BIC card (if available)? _____

Patient's name—Last First Middle initial

Date of birth (month/day/year) Gender Male Female Patient's social security number (SSN) *(optional)*

If you are homeless, check here. Enter the general location in the "Home address" section and complete the "Mailing address" section.

Home address Apartment number City State ZIP code

County of residence

Mailing address (if different from home address) Apartment number City State ZIP code

Mother's name—Last First Middle initial

For patients under one year of age, please complete this section.

Mother's date of birth (month/day/year) Mother's BIC or Medi-Cal card number or social security number

Parent/Legal Guardian Information

Name of parent/legal guardian or emancipated minor patient—Last First Middle initial

Home telephone number () Work telephone number () Message telephone number ()

What language do you speak at home? What language do you read best?

Certification

I am requesting a CHDP health examination today. I certify that I have read and understand this form. I declare that the information I have provided is true, correct, and complete.

Signature of parent/guardian or emancipated minor Relationship to patient Date

An individual has a right to review records containing his/her personal information. The official entity responsible for keeping the information is the Department of Health Care Services, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413. A copy of this information may be shared with the county Department of Social Services in the county in which you reside and will be kept with your child's medical record by your child's CHDP provider.

DHCS 4073 (Rev 10/13)

Sample: CHDP Program Pre-Enrollment Application (Form 4073)

December 2016

Health Assessment Intervals

Periodicity Schedule

Using the CHDP Gateway and performing CHDP services may only occur according to the periodicity schedule. A child may or may not be due to receive certain services based on their age and health history.

New Health Assessment Benefits

| Code | Service Description | Age | Rate |
|------|--|---|----------|
| B1 | Autism screening | 0 through 16 years, 11 months | \$ 54.90 |
| B2 | Dyslipidemia screening | 2 years through 20 years, 11 months | \$ 11.63 |
| B3 | Psychosocial/behavioral assessment | 0 through 20 years, 11 months | \$ 18.03 |
| B4 | Psychosocial/behavioral reassessment | 0 through 20 years, 11 months | \$ 17.44 |
| B5 | HIV screening (HIV-1 and HIV-2 single result) | 10 years, 11 months through 20 years, 11 months | \$ 12.33 |
| B6 | HIV screening (HIV-1 antigen[s], with HIV-1 and HIV-2 antibodies, single result) | 10 years, 11 months through 20 years, 11 months | \$ 20.26 |
| B7 | Alcohol and drug use assessment | 10 years, 11 months through 20 years, 11 months | \$ 24.00 |

The *Confidential Screening/Billing Report (PM 160)* claim form is not pre-printed with the new interim codes. For claim completion instructions, providers should follow the "Other Tests" instructions in the *Confidential Screening/Billing Report (PM 160) Claim Form: Completion Instructions* (conf clm comp) section of the CHDP Provider Manual.

Bright Futures

Under the Bright Futures health assessment periodicity schedule, 14 additional health assessments were added to the 15 health assessments previously reimbursable for children and youth from birth to 21 years of age.

Claims for the additional assessments shown below should be billed as Medically Necessary Interperiodic Health Assessments (MNIHAs) on the PM 160 claim form.

| | Infancy | Early Childhood | Middle Childhood | | | |
|-----------------|------------|-----------------|------------------|---------|---------|----------|
| Age | By 1 month | 30 months | 5 years | 7 years | 8 years | 10 years |
| Bill as a MNIHA | Yes | Yes | Yes | Yes | Yes | Yes |

| | Adolescence | | | | | | | |
|-----------------|-------------|----------|----------|----------|----------|----------|----------|----------|
| Age | 11 years | 12 years | 14 years | 15 years | 16 years | 18 years | 19 years | 20 years |
| Bill as a MNIHA | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

To bill one of the 14 health assessments, providers should enter, "There is a need to complete health assessment requirements" in the *Comments/Problems* area of the claim.

Provider types who use the *Confidential Screening/Billing Report* (PM 160 Information Only) for reporting purposes also should follow the preceding instructions for reporting the 14 additional assessments.

Medically Necessary Interperiodic Health Assessments

There may be circumstances when CHDP services are not in accordance with the periodicity schedule. These circumstances are called Medically Necessary Interperiodic Health Assessments (MNIHA). There are six MNIHA reasons:

- School or pre-school entrance
- Sports/camp physical examination
- Foster care/out-of-home placement
- Additional anticipatory guidance
- History of perinatal problems
- Significant developmental disabilities

NOTES

Table 21.1 CHDP PERIODICITY SCHEDULE FOR HEALTH ASSESSMENT REQUIREMENTS BY AGE GROUPS

| Screening Requirement ¹ | Age of Person Being Screened | | | | | | | | | | | | | | | |
|--|------------------------------|-------|-------|-------|-------|--------|--------|--------|------|------|--------|--------|---------|----------|----------|--|
| | ≤1 mo | 2 mos | 4 mos | 6 mos | 9 mos | 12 mos | 15 mos | 18 mos | 2 Yr | 3 Yr | 4-5 Yr | 6-8 Yr | 9-12 Yr | 13-16 Yr | 17-20 Yr | |
| Interval Until Next CHDP Exam | 1 mo | 2 mos | 2 mos | 3 mos | 3 mos | 3 mos | 3 mos | 6 mos | 1 yr | 1 yr | 2 yr | 3 yr | 4 yr | 4 yr | None | |
| History and Physical Examination ⁷ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Dental Assessment ⁸ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Nutritional Assessment | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Psychosocial/Behavioral Assessment ⁴ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Developmental Screening ⁵ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Developmental Surveillance | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Tobacco Assessment | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Pelvic Exam ⁶ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Measurements | | | | | | | | | | | | | | | | |
| Head Circumference | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Height/Length and Weight | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| BMI Percentile | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Blood Pressure ⁹ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Sensory Screening | | | | | | | | | | | | | | | | |
| Vision ⁷ – Visual Acuity Test | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Vision ⁷ – Clinical Observation | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Hearing ⁷ – Audiometric | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Hearing ⁷ – Clinical Assessment | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Procedures/Tests | | | | | | | | | | | | | | | | |
| Hemato/crit or Hemoglobin ³ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Blood Lead Risk Assessment/ Anticipatory Guidance ¹⁰ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Blood Lead Test ¹⁰ | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| TB Risk Assessment ¹² | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |
| Anticipatory Guidance | • | • | • | • | • | • | • | • | • | • | • | • | • | • | • | |

IMPORTANT USE INSTRUCTION:
THIS PERIODICITY SCHEDULE IS EFFECTIVE FOR DATES OF SERVICE PRIOR TO JULY 1, 2016 ONLY.

Note: The number of health assessments may be increased using MNIHA, as appropriate.¹

Note: Perform health assessment within 1 month of screening requirement age for children 2 years and under, and within 6 months for children 3 years and older.

Note: Children coming under care who have not received all the recommended procedures for an earlier age should be brought up-to-date as appropriate.

| Other Laboratory Tests | |
|--|--|
| When health history and/or physical examination warrants: | TST ¹² – see Tuberculosis HAG |
| Urine Dipstick of Urinalysis ¹¹ | Sickle Cell |
| FBG and Total Cholesterol | Papanicolaou (Pap) Smear |
| VDRL or RPR ¹³ | Chlamydia Test ¹³ |
| Annually if sexually active; more often as clinically indicated: | Immunizations ¹⁴ |

| Key: | |
|------|---|
| • | Required by CHDP one time within the interval given |
| ○ | Recommended by AAP, Bright Futures and CHDP |
| ★ | Perform when indicated by risk assessment |
| X | Perform if no documented lead level at 24 months |

- CHDP intervals are greater than recommended by Bright Futures. Providers may use MNIHA for necessary assessments that fall outside of periodicity such as school, sports or camp physical, foster care or out-of-home placement, or follow-up indicated by findings on a prior health assessment that need monitoring including additional anticipatory guidance, perinatal problems or significant developmental delay.
- Age-appropriate physical examination, including oral examination, is essential with child unclothed, and draped for older child or adolescent.
- See Dental HAG.
- Schedule indicates recommended ages for developmental screening and psychosocial/behavioral assessment. For reimbursement information, see CHDP PIN 08-14.
- Pelvic exam recommended within 3 years of first sexual intercourse. Subsequent pelvic exams may be performed as part of MNIHA when clinically indicated by symptoms such as pelvic pain, dysuria, dysmenorrhea. See STI HAG.
- Blood pressure before 3 years for at risk patients, then at each subsequent health assessment. See Blood Pressure HAG.
- See Vision Screening HAG.
- See Hearing Assessment HAG.
- Hb/Hct starting at 9-12 months of age. See Iron Deficiency Anemia (IDA) HAG.
- Test between the ages of 2 and 6 years if no documented lead level at or after 24 months. Test at any age when indicated by risk assessment or if lead risk changes. See Lead HAG.
- Urine Dipstick or Urinalysis only when clinically indicated. See Urinalysis HAG.
- Tuberculosis risk factor screen at each visit. TST when indicated. See TB HAG.
- STI testing when risk identified by history/physical. See STI HAG.
- Provide immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

Sample: CHDP Periodicity Schedule for Health Assessment Requirements by Age Groups (Table 21.1)

Federal Requirements

It is **extremely important** for all providers to accurately complete the *Confidential Screening/Billing Report* (PM 160) standard or information-only claim forms. The CHDP program monitors compliance under the Federal Title V Maternal and Child Health Block Grant Program to collect specific information about services provided to children and youth and ensures the health of this population. Data collected for each encounter on the PM 160 form is used to complete federally mandated annual reports.

Billing Information

Claim Forms

Providers use the PM 160 form to request payment and/or to document health assessment services given to eligible CHDP patients.

There are two types of PM 160 claim forms:

- Standard PM 160
- Information-only PM 160

Standard PM 160 Claim Form

The standard PM 160 claim form is used for billing and reporting preventive health services provided to full-scope and limited-scope Medi-Cal eligible patients who are not enrolled in a Medi-Cal managed care plan that covers these services. These patients include:

- Fee-for-service, full-scope Medi-Cal recipients younger than 21 years of age who have no Share of Cost (SOC), including individuals pre-enrolled through the CHDP Gateway program
- Full-scope Medi-Cal recipients younger than 21 years of age who are enrolled in a Medi-Cal managed care plan in which CHDP services are not capitated
- Individuals pre-enrolled through the Gateway and eligible for CHDP benefits only

For an example of the standard PM 160, refer to page 12.

Information-Only PM 160 Form

The information-only PM 160 form is used for reporting preventive health services provided to Medi-Cal recipients in order to meet federal Medicaid reporting requirements. This form is used to report services provided to patients who are:

- Enrolled in a Medi-Cal Managed Care Plan in which CHDP services are capitated
- Receiving services from a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Indian Health Services (IHS)

For an example of the information-only PM 160, refer to page 13.

Standard PM 160 Claim Form

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PATIENT NAME (LAST) (FIRST) (INITIAL) MEDICAL RECORD NO. LA Code 94 42080201 J

BIRTHDATE (Mo. Day Year) AGE SEX M/F PATIENT'S COUNTY OF RESIDENCE CO. CODE TELEPHONE NUMBER NEXT CHDP EXAM (Mo. Day Year)

RESPONSIBLE PERSON (NAME) (STREET) (APT./SPACE #) (CITY) (ZIP)

Ethnic Code: 1-American Indian, 2-Asian, 3-Black, 4-Filipino, 5-Mex. Amer./Hispanic, 6-White, 7-Other, 8-Pacific Islander

CHDP ASSESSMENT Indicate outcome for each screening procedure

| | | | | |
|----------------------|---------------------------------------|--|-----------------|--|
| NO PROBLEM SUSPECTED | REFUSED, CONTRA-INDICATED, NOT NEEDED | PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column | DATE OF SERVICE | FOLLOW UP CODES |
| ✓ A | ✓ B | NEW C KNOWN D | Mo. Day Year | 1. NO DX/RX INDICATED OR NOW UNDER CARE. 2. QUESTIONABLE RESULT, RECHECK SCHEDULED. 3. DX MADE AND RX STARTED. 4. DX PENDING/RETURN VISIT SCHEDULED. 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX. 6. REFERRAL REFUSED. |

| | | | | | |
|---|--|--|--|--|----|
| 01 HISTORY and PHYSICAL EXAM | | | | | 01 |
| 02 DENTAL ASSESSMENT/REFERRAL | | | | | |
| 03 NUTRITIONAL ASSESSMENT | | | | | |
| 04 ANTICIPATORY GUIDANCE HEALTH EDUCATION | | | | | |
| 05 DEVELOPMENTAL ASSESSMENT | | | | | |
| 06 SNELLEN OR EQUIVALENT | | | | | 06 |
| 07 AUDIOMETRIC | | | | | 07 |
| 08 HEMOGLOBIN OR HEMATOCRIT | | | | | 08 |
| 09 URINE DIPSTICK | | | | | 09 |
| 10 COMPLETE URINALYSIS | | | | | 10 |
| 12 TB MANTOUX | | | | | 12 |

REFERRED TO: TELEPHONE NUMBER

REFERRED TO: TELEPHONE NUMBER

COMMENTS/PROBLEMS
IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

HEIGHT IN INCHES 0 WEIGHT LBS 4 BLOOD PRESSURE

BODY MASS INDEX (BMI) PERCENTILE HEMOGLOBIN HEMATOCRIT

BIRTH WEIGHT LBS OZS

ROUTINE REFERRAL(S) (✓) PATIENT IS A FOSTER CHILD (✓)

BLOOD LEAD DENTAL

IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

| | |
|--------------------------|--------------------------------|
| GIVEN TODAY | NOT GIVEN TODAY |
| NOW UP TO DATE FOR AGE A | STILL NOT UP TO DATE FOR AGE B |
| | ALREADY UP TO DATE FOR AGE C |
| | REFUSED OR CONTRA-INDICATED D |

DIAGNOSIS CODES

1 2

THE QUESTIONS BELOW MUST BE ANSWERED

- Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes No
- Tobacco Used by Patient Yes No
- Counseled About/Referred For Tobacco Use Prevention/Cessation. Yes No

PATIENT VISIT (✓) TYPE OF SCREEN (✓) TOTAL FEES

1 New Patient or Extended Visit 2 Routine Visit 1 Initial 2 Periodic

1 Enrolled in WIC 2 Referred to WIC

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

PROVIDER NUMBER PLACE OF SERVICE

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

This is to certify that the screening information is true and complete, and the results explained to the child or his parent or guardian. I understand that payment and satisfaction of this claim may be from Federal or State funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable Federal or State law. I also certify that none of the services billed on this form have been or will be billed to Medi-Cal, the patient, or other insurance providers.

- 1 If covered by Medi-Cal, or pre-enrolled in CHDP Gateway, enter BIC number.
- 2 Patient eligible for CHDP benefits only.

SIGNATURE OF PROVIDER DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

Information-Only PM 160 Form

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PATIENT NAME (LAST) (FIRST) (INITIAL) MEDICAL RECORD NO. LA Code 94 42080201 J

BIRTHDATE (Mo. Day Year) AGE SEX M/F PATIENT'S COUNTY OF RESIDENCE CO. CODE TELEPHONE NUMBER NEXT CHDP EXAM (Mo. Day Year)

RESPONSIBLE PERSON (NAME) (STREET) (APT./SPACE #) (CITY) (ZIP) Ethnic Code

1-American Indian
2-Asian
3-Black
4-Filipino
5-Mex. Amer./Hispanic
6-White
7-Other
8-Pacific Islander

| CHDP ASSESSMENT Indicate outcome for each screening procedure | NO PROBLEM SUSPECTED √ A | REFUSED, CONTRA-INDICATED, NOT NEEDED √ B | PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column | | DATE OF SERVICE Mo. Day Year | FEES |
|--|-----------------------------|--|---|------------|---------------------------------|------|
| | | | NEW C | KNOWN D | | |
| 01 HISTORY and PHYSICAL EXAM | | | | | 01 | |
| 02 DENTAL ASSESSMENT/REFERRAL | | | | | | |
| 03 NUTRITIONAL ASSESSMENT | | | | | | |
| 04 ANTICIPATORY GUIDANCE HEALTH EDUCATION | | | | | | |
| 05 DEVELOPMENTAL ASSESSMENT | | | | | | |
| 06 SNELLEN OR EQUIVALENT | | | | | 06 | |
| 07 AUDIOMETRIC | | | | | 07 | |
| 08 HEMOGLOBIN OR HEMATOCRIT | | | | | 08 | |
| 09 URINE DIPSTICK | | | | | 09 | |
| 10 COMPLETE URINALYSIS | | | | | 10 | |
| 12 TB MANTOUX | | | | | 12 | |
| CODE OTHER TESTS PLEASE REFER TO THE CHDP LIST OF TEST CODES | | | | | CODE OTHER TESTS | |

FOLLOW UP CODES

1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED

4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

REFERRED TO: TELEPHONE NUMBER

REFERRED TO: TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

HEIGHT IN INCHES WEIGHT LBS OZS BODY MASS INDEX (BMI) PERCENTILE BLOOD PRESSURE

HEMOGLOBIN HEMATOCRIT BIRTH WEIGHT LBS OZS

IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

| GIVEN TODAY | | NOT GIVEN TODAY | |
|-----------------------------|-----------------------------------|---------------------------------|----------------------------------|
| NOW UP TO DATE FOR AGE A | STILL NOT UP TO DATE FOR AGE B | ALREADY UP TO DATE FOR AGE C | REFUSED OR CONTRA-INDICATED D |
| | | | |

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (✓) PATIENT IS A FOSTER CHILD (✓)

BLOOD LEAD DENTAL

DIAGNOSIS CODES

1 2

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes No

2. Tobacco Used by Patient Yes No

3. Counseled About/Referred For Tobacco Use Prevention/Cessation. Yes No

PATIENT VISIT (✓) TYPE OF SCREEN (✓)

New Patient or Extended Visit Routine Visit Initial Periodic

TOTAL FEES

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE / PROVIDER NUMBER

PLACE OF SERVICE

Enrolled in WIC Referred to WIC

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

PARTIAL SCREEN SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

PM 160 INFORMATION ONLY (03/07)

CONFIDENTIAL SCREENING/BILLING REPORT

Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC) Billing Requirements

The CHDP information-only *Confidential Screening/Billing Report* (PM 160) collects the required data and enables the CHDP program to monitor compliance with federal requirements. FQHCs and RHCs enrolled as CHDP providers who render EPSDT services must submit claims and PM 160 forms as follows:

For services rendered to children with fee-for-service, full scope Medi-Cal or to children pre-enrolled in temporary, fee-for-service Medi-Cal through the CHDP Gateway process:

- Submit both a *UB-04* (following standard outpatient *UB-04* claim completion guidelines) and an information-only PM 160 form (according to the PM 160 instructions)
- Do not attach the *UB-04* form to the information-only PM 160 form or vice versa
- Send the *UB-04* and information-only PM 160 forms to the respective addresses

For services rendered to children eligible for state-funded CHDP services only:

Submit a standard PM 160 (according to the following PM 160 instructions)

- Do not submit a *UB-04*

Electronic Billing – Computer Media Claims (CMC)

Providers have the option to submit both the standard and information-only PM 160 forms electronically. The advantage of electronic submissions is that fee-for-service providers can be paid in a more timely fashion and information is transmitted with more accuracy. To submit Computer Media Claims (CMC), providers must complete an application/agreement from DHCS and follow all CMC enrollment requirements and procedures as outlined in the *CMC Enrollment Procedures* section (cmc enroll) in the Part 1 Medi-Cal provider manual. Providers should work with their respective CHDP county operation to complete the application. Providers may also call the Telephone Service Center (TSC) at 1-800-541-5555 to receive an application or to learn more about this option.

DHCS Fiscal Intermediary (FI) Contacts

Telephone Service Center (TSC): 1-800-541-5555

POS/Internet Help Desk: 4, Option 2

POS/Internet assistance is available between 6 a.m. and midnight, seven days a week to help with these tasks:

- Troubleshooting the computer to make sure it has correct technical specifications
- Accessing the correct software and browser
- Accessing the CHDP Gateway Internet transaction
- Setting up the POS device
- Completing the test transaction and setting up a shortcut key
- Answering questions about the POS device
- Processing requests for a POS device

The FI Provider Relations Organization (PRO) uses a Customer Relationship Management (CRM) tracking system to monitor and track provider inquiries. A unique number is assigned to each call that will help in providing a timely and accurate resolution. When calling TSC, the FI agent will provide a CRM Service Request Number.

Claim Completion

PM 160 Claim Form

For detailed claim completion instructions, see the CHDP provider manual section, *Confidential Screening/Billing Report (PM 160) Claim Form: Completion Instructions*. The CHDP manual locator key is _____. The standard PM 160 and the information-only PM 160 forms are supplied by the local CHDP program. Clinical laboratory providers (including those with blood lead proficiency) request PM 160 forms from the local CHDP program in the jurisdiction where the laboratory is located.

Clinical laboratories should refer to the *Confidential Screening/Billing Report (PM 160) Claim Form: Completion Instructions for Labs* section (conf clm comp lab) in the CHDP provider manual.

Billing Tip: If the patient name, birthday or gender differs from the information listed on the BIC or the Medi-Cal eligibility verification system, list the information as it appears in the Medi-Cal eligibility verification system in the related fields of the PM 160. Explain the discrepancy and correct information in the *Comments/Problems* area of the claim form.

Answer Key: conf clm comp

Selected PM 160 Form Field Descriptions

| Field Name | Description |
|--|--|
| Medical Record Number | <p>Use this optional field to enter the patient's record or account number assigned by the provider. This number will appear on the CHDP <i>Remittance Advice Details</i> (RAD).</p> <p>Enter the patient's age with one of the following indicators: "y" for years, "m" for months, "w" for weeks or "d" for days. For example, 15 years of age is entered as _____.</p> <p>Enter all dates in six-digit (MMDDYY) format. Use lead-in zeros for dates with a single digit. For example, January 4, 2016 is entered as "010416".</p> |
| Patient's County of Residence And Code | <p>Enter the name and appropriate two-digit code where the patient lives. If the patient lives in Berkeley, Long Beach or Pasadena, enter a two-digit city code. All county and city codes are listed in the CHDP provider manual, <i>Confidential Screening/Billing Report</i> (PM 160) <i>Claim Form: Completion Instructions</i> section (conf clm comp).</p> |
| Next CHDP Exam | <p>For children younger than 3 years of age, enter the month, day and year (MMDDYY) that the next complete health assessment is due. Enter all dates in six-digit (MMDDYY) format. For children 3 years of age and older, enter only the month and year of the next appointment. Enter all dates in four-digit (MMYY) format.</p> <p>Note</p> <p>Use lead-in zeros when entering dates of only one digit. For example, May 1, 2016 is entered as "050116." A common error is that the service provided date is listed before the date of birth.</p> |
| Date of Service | <p>Enter the date the CHDP service was rendered in six-digit format. Use lead-in zeroes when entering dates of only one digit. For example, May 1, 2016 is entered as "050116." If the procedures were performed on different days, enter the date of the history and physical exam.</p> <p>Billing Tip: Verify that the month and year of the "Date of Service" are the same as the month and year of eligibility for services.</p> <p>Note</p> <p>A common error is that the service provided date is listed before the date of birth.</p> |

Answer Key: 15y

Selected PM 160 Form Field Descriptions (continued)

There are 11 pre-printed screening procedures listed on the PM 160 under “CHDP Assessment.” Every screening procedure must have a check mark (√) in column A or B or a numeric follow-up code in column C and/or D. Check marks should not be entered in column C or D. However, numeric follow-up codes can be entered in both columns C and D when a screening reveals both a new problem and the reoccurrence of an old problem.

| Field Name | Description |
|---|--|
| No Problem Suspected; Column A | Enter a check mark (√) in this column if the procedure is performed and no problem is suspected. |
| Refused, Contraindicated, Not Needed; Column B | Enter a check mark (√) when the procedure was refused for any reason, or the patient is unable to cooperate in a procedure. Explain in the <i>Comments/Problems</i> field when a child does not receive a test appropriate to the child’s age according to the periodicity schedule. Do not check column B when laboratory tests are performed outside of the provider’s office. Enter the results of the test even though no fee is charged to CHDP. |
| Problem Suspected; Columns C and D | <p>Enter the numeric follow-up code in the appropriate column when a condition is:</p> <ul style="list-style-type: none"> • Not known to the family per history or is not currently/previously under care; <u>column C</u> • Known to the family per history or previously under care; <u>column D</u> <p>All numeric follow-up codes are listed in the <i>Confidential Screening/Billing Report (PM 160) Claim Form: Completion Instructions</i> (conf clm comp) section of the CHDP provider manual.</p> |
| Other Tests | Additional screening procedures (such as sickle cell, lead, blood glucose, total cholesterol, etc.) are listed with the corresponding billing codes (13-26) in the <i>Confidential Screening/Billing Report (PM 160) Claim Form: Completion Instructions</i> (conf clm comp) section of the CHDP provider manual. New health assessment benefit codes B1 – B7 are effective July 1, 2016. |
| Height, Weight, Body Mass Index Percentile (BMI), Blood Pressure, Hemoglobin, Hematocrit and Birth Weight | <p>Complete all information, with lead-in zeros as applicable. For example:</p> <ul style="list-style-type: none"> • Weight: If the patient weighs 95 pounds and 3 ounces, enter the weight as 095 pounds and 03 ounces. This must be a three-digit format in pounds and a two-digit format in ounces. • Height: Enter the height (or length) in inches to the nearest quarter inch. Fill in all spaces. A “4” is pre-printed in the last (right) space. Convert all fractions of an inch to fourths and enter as follows: <ul style="list-style-type: none"> – Whole inches: enter “0” – ¼ inch: enter “1” – ½ inch: enter “2” – ¾ inch: enter “3” • Hemoglobin: Enter the hemoglobin to the nearest 0.1 gram. Always enter three digits so that every box is filled. Add leading zeroes when needed. Do not leave a box empty. <ul style="list-style-type: none"> – Example: A hemoglobin level of 8.5 grams is recorded as 08.5 |

| Field Name | Description |
|---|--|
| Height, Weight, Body Mass Index Percentile (BMI), Blood Pressure, Hemoglobin, Hematocrit and Birth Weight <i>(continued)</i> | <ul style="list-style-type: none"> • Hematocrit: Record numbers to the nearest whole number. Do not enter more than two digits, only whole numbers. <ul style="list-style-type: none"> – Do not enter tenths, such as 34.1 percent – Do not enter % marks – Example: 34.1 percent – 34.4 percent would be entered as 34 – Example: 34.5 percent – 34.9 percent would be entered as 35 • BMI: For children 2 years of age and older, identify BMI based upon the patient’s height and weight. Plot the BMI number on the “BMI-for-Age” chart which can be found in the <i>Appendix</i> section of the CHDP provider manual. Enter BMI using two whole numbers; it is a two-digit field. • B/P: Record the systolic and diastolic blood pressure for children 3 years and older. • Birth Weight: Enter the birth weight, if known, in pounds and ounces for children younger than 2 years of age. This must be a two-digit format in pounds and a two-digit format in ounces. |
| Immunizations | Enter the code for the immunization and the name of the vaccine on a blank line in the <i>Immunizations</i> area. Enter a check mark (✓) in column A or B, as appropriate: <ul style="list-style-type: none"> • Enter a check mark (✓) in <u>column A</u> to indicate that the immunization given today brings the patient up-to-date for their age • Enter a check mark (✓) in <u>column B</u> to indicate that the immunization given today does not bring the patient up-to-date for their age • Columns C and D are used to record immunizations for which the patient was assessed but not given at the time of the health assessment: <ul style="list-style-type: none"> – Enter a check mark (✓) in <u>column C</u> to indicate the immunization status is current or the patient has had the disease – Enter a check mark (✓) in <u>column D</u> to indicate the immunization was refused or the needed dose is medically contraindicated or is deemed inappropriate |
| Patient Visit | Required for the standard PM 160 claim form. (Not applicable to the information-only PM 160.) <p>Enter a check mark (✓) in the <i>New Patient or Extended Visit</i> field if the patient has not previously received a CHDP health assessment by this provider and no CHDP health assessment record is established with this provider.</p> <p>Enter a check mark (✓) in the <i>New Patient or Extended Visit</i> field if the patient requires as much or more time to be assessed, as does a new patient, and explain the reason in the <i>Comments/Problems</i> field.</p> <p>Enter a check mark (✓) in the <i>Routine Visit</i> field if the patient’s visit is a routine return visit and the visit requires less time than ordinarily needed with a new patient or for an extended visit.</p> |

| Field Name | Description |
|------------------------------|--|
| Type Of Screen | <p>Required for the standard PM 160 claim form. (Not applicable to the information-only PM 160.)</p> <p>Enter a check mark (✓) in the Initial box if this is the first known CHDP health assessment (by any provider) for this patient.</p> <p>Enter a check mark (✓) in the <i>Periodic</i> field if the patient has previously received a CHDP health assessment by any provider.</p> |
| Fees | <p>Required for the standard PM 160 claim form. (Not applicable to the information-only PM 160). Providers should list their usual and customary charge on the line that matches the screening procedure and/or immunization code being billed. Refer to the <i>Rates: Maximum Reimbursement for CHDP</i> section (rates max chdp) of the CHDP provider manual.</p> |
| Service Location | <p>Enter name, address (include the 9-digit ZIP code) and telephone number (include area code) where the service was provided.</p> |
| Provider Number | <p>Enter the appropriate provider number in spaces beginning to the left. Ensure the provider number is entered accurately and legibly; claims are automatically paid to the provider number listed on the PM 160.</p> <p>The three-digit health plan code number is entered on the information-only PM 160 claim form for Medi-Cal managed care health plans.</p> <p>NOTE</p> <p>If an individual provider is enrolled as a managed care provider, the provider should use the health plan's three-digit code, not their individual provider number.</p> <p>FQHCs, RHCs and IHSs enter the provider number, instead of a health plan code number, on the information-only PM 160 claim form.</p> |
| Place of Service | <p>Enter the two-digit Place of Service code that best describes where the service was rendered:</p> <ul style="list-style-type: none"> • Code 11: Office (any location other than Place of Service code 22 or 71) • Code 22: Outpatient Hospital • Code 71: State or Local Public Health Clinic • Code 81: Independent Laboratory • Code 99: Other <p>NOTE</p> <p>this field is typically left blank</p> |
| Referred to/Telephone Number | <p>When referrals are made to other providers, enter the name and telephone number of the other provider or agency, if available. When two or more referrals are made, additional provider names and telephone numbers should be entered in the <i>Comments/Problems</i> field.</p> |

| Field Name | Description |
|-------------------|--|
| Comments/Problems | <p>This area should be used for remarks that clarify the results of the health assessment and communicate issues to the local and State CHDP programs.</p> <p>NOTE</p> <p>This field usually does not contain enough detail and could affect provider reimbursement and/or CHDP program federal funding.</p> <p>The reason a MNIHA service was performed must be included in the <i>Comments/Problems</i> field, if applicable. The six MNIHA justifications are listed in the CHDP Applications section of this module. The reason for a MNIHA must be determined _____ to submitting the CHDP Gateway transaction.</p> <p>Examples that may require more documentation:</p> <ul style="list-style-type: none"> • Diagnosis and related ICD-10-CM code, if a diagnosis is made during the visit. Reference the line number and follow-up when documenting diagnosis. • Identification of dental care (last dental care) for children 3 years of age and older. Document the severity of dental problems according to the American Dental Association’s Classification of Treatment Needs (see appendix in the provider manual). • Explanation of a procedure (normally recommended for the child’s age) that is not performed, including tests performed at an age younger than the age specified. • Documentation of the head circumference measurement for children 2 years of age and younger. Record measurements to one-fourth (¼) inch. • Results of tests – vision test, blood lead tests, blood glucose test, cholesterol test, etc. • Explanation of the mother’s Medi-Cal identification number being used to bill for services rendered to an infant (during the month of birth or the month following). • The reason for additional time spent with the patient when billing for an “Extended Visit” for other than new patients or patients not assessed within the last two years. • Document if patient did not return for the reading of a TB skin test. • Note discrepancies between known information and information provided by the eligibility verification system, for example gender or spelling of name. • Document when immunization administered because individual is in a high-risk category. • Use the Comments/Problems section for remarks that clarify the results of the health assessment and to communicate information to the local and State CHDP programs. • Bright Futures assessments. • Following are examples of information to include when appropriate: <ul style="list-style-type: none"> – The reason(s) for performing Medically Necessary Interperiodic Health Assessments (MNIHAs). – Must document even if the reason was identified in the drop down menu during Gateway transaction. |

Answer Key: prior

| Field Name | Description |
|-------------------------------------|---|
| Routine Referrals | <ul style="list-style-type: none"> • Blood Lead <ul style="list-style-type: none"> – Enter a check mark (√) in the Blood Lead box when a child has been referred to a laboratory for the collection of a blood specimen for the lead test. • Dental <ul style="list-style-type: none"> – Enter a check mark (√) in the Dental box only when no dental problem is suspected, but you have advised the parents to obtain the annual preventive dental care for a Medi-Cal child. Annual referrals are required at age 3 and recommended at age 1 for prevention and maintenance of oral health. (Refer to CHDP Dental Periodicity for further information regarding frequency of exams.) <p>NOTE This field is typically left blank.</p> |
| Patient is a Foster Child | <p>Enter a check mark (√) when the patient is in a foster care home or has been placed with a relative by the county’s social services department.</p> <p>NOTE This field is typically left blank.</p> |
| Diagnosis Codes | <p>Enter the <i>International Classification of Diseases</i> code in the <i>Diagnosis Codes</i> area for each condition or problem suspected.</p> <p>If the diagnosis code is fewer than five numbers, enter zeros in the last (right) spaces of the box. For example, ICD-10-CM diagnosis code J02.0 (streptococcal pharyngitis) is entered as J0200 and ICD-10-CM diagnosis code J45.909 (unspecified asthma, uncomplicated asthma) is entered as J45909.</p> <p>NOTE This field is typically left blank.</p> <p>Important: No ICD indicator is required on the standard PM 160 claim or PM 160 Information Only. Do not leave blank spaces in the boxes.</p> |
| The Question Below Must be Answered | <p>Enter the patient’s response to the questions regarding smoking.</p> <p>NOTE These fields must be filled in.</p> |

| Field Name | Description |
|----------------|---|
| Partial Screen | <p>A prior CHDP health assessment should have been performed before billing for a partial screen. A partial screen is defined as follows:</p> <ul style="list-style-type: none"> • Procedure(s) performed that could not be provided during a previous CHDP health assessment; and/or • Necessary immunizations administered when another complete CHDP health assessment is not yet due; and/or • Procedures required by the Women, Infants and Children (WIC) Supplemental Nutrition Program for children who have had a complete CHDP health assessment but are not yet due for another complete health assessment <p>If this CHDP health assessment is for a partial screen, complete the <i>Screening Procedure</i> and <i>Immunizations</i> fields to indicate services rendered for this visit. Enter appropriate remarks, such as justification for the partial screen, in the <i>Comments/Problems</i> field. More information about partial screens is located in the CHDP provider manual, <i>Child Health and Disability Prevention (CHDP) Program: Billing and Reimbursement</i> section (child health bil).</p> <p>Billing Tip: For a partial screen, enter the date of the complete CHDP health assessment from the prior PM 160 or the future date of the CHDP health assessment in the <i>Accompanies Prior PM 160 Dated</i> field (denial code 0035).</p> <p>NOTE</p> <p>This field is typically left blank. This affects federal funding to the CHDP program.</p> |

| Field Name | Description |
|--|---|
| <p>Screening Procedure Recheck</p> | <p>A screening procedure recheck is performed when the accuracy of the prior health assessment was questioned and follow-up code 2 (questionable result) was entered in column C or D on the previous PM 160 claim form.</p> <p>Similar to completing the PM 160 claim form for a partial screen, complete the <i>Screening Procedure</i> and <i>Immunizations</i> areas to indicate the services rendered for this visit. However, only screening procedures 06 through 20 and 22 may be submitted for reimbursement as rechecks. Codes 21 and 23 through 26 may be repeated as medically appropriate.</p> <p>Billing Tip: For a screening procedure recheck, enter the date of the complete CHDP health assessment from the prior PM 160 claim form in the <i>Accompanies Prior PM 160 Dated</i> field (denial code 0035).</p> <p>NOTE This field is typically left blank.</p> |
| <p>Patient Eligibility (Standard PM 160)</p> | <p>Providers must enter the 14-character BIC identification number, along with the two-digit county code and the two-digit aid code, when completing the <i>Patient Eligibility</i> section on the standard PM 160 claim form. Enter a check mark (√) to indicate the patient is covered by Medi-Cal or is pre-enrolled through the CHDP Gateway, or eligible for CHDP benefits only.</p> <p>NOTE The client's Social Security Number (SSN) cannot be used when completing the <i>Patient Eligibility</i> section of the PM 160. These fields are typically not filled out correctly:</p> <ul style="list-style-type: none"> • A two-digit county code • Two-digit aid code • Fourteen-digit identification number |
| <p>Patient Eligibility (Information-Only PM 160)</p> | <p>Patient eligibility information is completed the same as for the standard PM 160 claim form, except there are no boxes checked to indicate Medi-Cal/Gateway/CHDP coverage.</p> |

Claim Submission

Claim Distribution Details

The standard and information-only PM 160 claim forms include four copies, which are distributed in the order below.

Copy 1 (White)

The white copy is forwarded to the CHDP FI for claims payment and/or reporting.

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

Copy 2 (Yellow)

The yellow copy must be sent to the local CHDP program within 30 days of the health assessment. This copy assists local programs with ensuring that patients who are not enrolled in Medi-Cal managed care plans are able to obtain diagnosis and treatment services, if needed.

NOTE

The yellow copy must also be sent by Medi-Cal managed care plans to the local county CHDP program for monitoring purposes. CMC billers must also submit a copy of the PM 160 to the local county CHDP program.

Copy 3 (White)

The provider must keep the second white copy in the patient's medical record.

Copy 4 (Pink)

The pink copy is to be given to the parent, guardian or emancipated minor. The document contains a summary of the services the patient just received.

NOTE

A typical error occurs when a submitter mails all copies to the FI or DHCS CHDP program.

Claim Preparation Tips

The following preparation tips help ensure that the DHCS Fiscal Intermediary's Optical Character Recognition (OCR) equipment can scan the submitted form, and also ensure the return of the claim to the provider in the event of postal delivery difficulties.

- Type information onto the PM 160 or fill out with black ink. Do not use pencil or red ink. Press hard so all four copies are legible. Do not use "white out" or any other correction fluid.
- Do not use a highlighter.
- Place staples in the designated area (upper right corner) of the claim form.
- Legibly enter the provider's name and return address on the outside of the envelope.

Billing Tips

The following information will help providers with the billing process. It is located in the *Confidential Screening/Billing Report (PM 160) Claim Form: Tips for Billing* section (conf clm tips) in the CHDP provider manual. Prompt payment of CHDP program claims is dependent on how accurately the PM 160 is completed. Providers should ensure that:

- The PM 160 is signed by the provider or designated representative. Do not use a signature stamp.
- The PM 160 is completely filled out for the type of assessment rendered (complete, partial or recheck).
- All the required checkmarks, code numbers and fees are entered.
- The provider number is accurate. Reimbursement is directed to the provider according to the provider number entered on the PM 160.
- The BIC number entered on the PM 160 belongs to the individual for whom services were rendered and the recipient was eligible for services during the month services were rendered.
- All comments, concerns or problems are entered in the *Comments/Problems* field.
- The recipient date of birth matches the date of birth on the Medi-Cal eligibility file (even if it is incorrect on the file).
- Service location (address, including the 9-digit ZIP code, where service was provided) must match the service address on the CHDP Provider Master File (PMF).
- The appropriate two-digit Place of Service code must be entered.

Additional Billing Assistance Information

There are 61 CHDP programs throughout the state. These local CHDP programs administer the program on a day-to-day basis. They are responsible for provider recruitment, outreach to families, community education, care coordination and implementation of state and federal regulations pertaining to the program. The local CHDP programs can be found under “Resource – Local CHDP Directory” in this module.

For additional information about claim processing for the PM 160, claim follow-up, submitting a PM 160 tracer and appealing denied CHDP claims, see the CHDP provider manual *Child Health and Disability Prevention (CHDP) Program: Claims Processing* section. The CHDP manual locator key is _____.

Resource – Local CHDP Directory

To find out more about CHDP services, please contact your local CHDP office.
A copy of the County Offices directory is available on the DHCS website at
(www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx).

| County | CHDP Office Address | CHDP Phone | CHDP Fax |
|------------------|--|--------------|--------------|
| Alameda | 1000 San Leandro Blvd, Suite 200 San Leandro, CA 94577-1674 | 510-618-2070 | 510-618-2077 |
| Alpine | 75-B Diamond Valley Road, Markleeville, CA 96120-9579 | 530-694-2146 | 530-694-2252 |
| Amador | 10877 Conductor Blvd, Suite 400, Sutter Creek, CA 95685 | 209-223-6669 | 209-223-3524 |
| City of Berkeley | 1947 Center Street, Second Floor, Berkeley, CA 94704 | 510-981-5300 | 510-981-5345 |
| Butte | 82 Table Mountain Blvd, Suite 30, Oroville, CA 95965 | 530-538-6222 | 530-538-6218 |
| Calaveras | Mail: 891 Mountain Ranch Road, San Andreas, CA 95249-9713 Street: 700 Mountain Ranch Road, Suite C2 San Andreas, CA 95249 | 209-754-6460 | 209-754-6459 |
| Colusa | 251 East Webster Street, Colusa, CA 95932-2951 | 530-458-0380 | 530-458-4136 |
| Contra Costa | 597 Center Avenue, Suite 280, Martinez, CA 94553-4669 | 925-313-6150 | 925-313-6160 |
| Del Norte | 880 Northcrest Drive, Crescent City, CA 95531-9988 | 707-464-3191 | 707-465-4573 |
| El Dorado | 941 Spring Street #3, Placerville, CA 95667 | 530-621-6110 | 530-622-5109 |
| Fresno | Mail: P.O. Box 11867, Fresno, CA 93775-1867 Street: 1221 Fulton Mall, Fresno, CA 93721 | 559-600-3281 | 559-600-7726 |
| Glenn | 240 North Villa Avenue, Willows, CA 95988-2694 | 530-934-6588 | 530-934-6463 |
| Humboldt | 908 7th Street, Eureka, CA 95501 | 707-445-6210 | 707-476-4960 |
| Imperial | Mail: 935 Broadway Street, El Centro, CA 92243-2396 Street: 797 West Main Street, Suite A, El Centro, CA 92243 | 760-482-2769 | 760-336-3903 |

| County | CHDP Office Address | CHDP Phone | CHDP Fax |
|--------------------|---|--------------|--------------|
| Inyo | Mail: P.O. Box Drawer H, Independence, CA 93526 Street: 155 East Market Independence, CA 93526 | 760-878-0241 | 760-878-0266 |
| Kern | 1800 Mount Vernon Avenue, Second Floor Bakersfield, CA 93306-3302 | 661-321-3000 | 661-868-0493 |
| Kings | 330 Campus Drive, Hanford, CA 93230-4375 | 559-584-1401 | 559-582-6803 |
| Lake | 922 Bevins Court, Lakeport, CA 95453 | 707-263-1090 | 707-262-4280 |
| Lassen | 1445 Paul Bunyan Road, Susanville, CA 96130-3146 | 530-251-8183 | 530-251-2668 |
| City of Long Beach | 2525 Grand Avenue, Long Beach, CA 90815 | 562-570-7980 | 562-570-4099 |
| Los Angeles | 9320 Telstar Avenue, Suite 226, El Monte, CA 91731-2849 | 800-993-2437 | 626-569-9350 |
| Madera | 14215 Road 28, Madera, CA 93638-5715 | 559-675-7608 | 559-674-7262 |
| Marin | 3240 Kerner Blvd, San Rafael, CA 94901 | 415-473-4269 | 415-473-6396 |
| Mariposa | Mail: P.O. Box 5, Mariposa, CA 95338 Street: 4988 11th Street, Mariposa, CA 95338 | 209-966-3689 | 209-966-4929 |
| Mendocino | 1120 South Dora Street, Ukiah, CA 95482-8333 | 707-472-2600 | 707-472-2735 |
| Merced | 260 East 15th Street, Merced, CA 95340-6216 | 209-381-1125 | 209-381-1102 |
| Modoc | 441 North Main Street, Alturas, CA 96101 | 530-233-6311 | 530-233-5754 |
| Mono | Mail: P.O. Box 3329, Mammoth Lakes, CA 93546 Street: 437 Old Mammoth Road, Suite Q Mammoth Lakes, CA 93546 | 760-924-1830 | 760-924-1831 |
| Monterey | 1615 Bunker Hill Way, Suite 190, Salinas, CA 93906 | 831-755-4960 | 831-443-1123 |
| Napa | 2261 Elm Street, Building G, Napa, CA 94559-3721 | 707-253-4316 | 707-299-2123 |
| Nevada | 500 Crown Point Circle, Suite 110, Grass Valley, CA 95945 | 530-265-1462 | 530-271-0841 |

| County | CHDP Office Address | CHDP Phone | CHDP Fax |
|------------------|---|------------------------------|--------------|
| Orange | Mail: P.O. Box 6099, Santa Ana, CA 92706-0099 Street: 1725 West 17th Street, Santa Ana, CA 92706 | 714-567-6224 | 714-834-7948 |
| City of Pasadena | 1845 North Fair Oaks Avenue, Room 2137, Pasadena, CA 91103-6120 | 626-744-6015 | 626-396-7324 |
| Placer | 11484 B Avenue, Auburn, CA 95603-2603 | 530-886-3620 | 530-886-3606 |
| Plumas | 270 County Hospital Road, Suite 111 Quincy, CA 95971 | 530-283-6330 | 530-283-6110 |
| Riverside | Mail: P.O. Box 7600, Riverside, CA 92513-7600 Street: 10769 Hole Avenue, Suite 210, Riverside, CA 92505 | 951-358-5481 | 951-358-5002 |
| Sacramento | 9616 Micron Avenue, Suite 950 Sacramento, CA 95827 | 916-875-7151 | 916-875-9773 |
| San Benito | 439 Fourth Street, Hollister, CA 95023-3801 | 831-637-5367 | 831-637-9073 |
| San Bernardino | 606 East Mill Street, San Bernardino, CA 92415-0475 | 909-387-6499 | 909-387-6348 |
| San Diego | Mail: P.O. Box 85222 San Diego, CA, 92186-5222 Street: 3851 Rosecrans Street San Diego, CA 92110 | 619-692-8808 | 619-692-8827 |
| San Francisco | 30 Van Ness, Suite 210, San Francisco, CA 94102-6082 | 415-575-5712 | 415-558-5905 |
| San Joaquin | Mail: P.O. Box 2009, Stockton, CA 95201-2009 Street: 420 S Wilson Way, Stockton, CA 95205 | 209-468-8335 | 209-468-2072 |
| San Luis Obispo | Mail: P.O. Box 1489, San Luis Obispo, CA 93406-1489 Street: 2180 Johnson Avenue, San Luis Obispo, CA 93401 | 805-781-5502 | 805-781-5504 |
| San Mateo | 2000 Alameda de las Pulgas, Suite 210 San Mateo, CA 94403 | 650-573-2877 | 650-573-2859 |
| Santa Barbara | 345 Camino del Remedio, Third Floor, Santa Barbara, CA 93110 | 805-681-5360 | 805-681-4958 |
| Santa Clara | 1993 B McKee Road, San Jose, CA 95116 | 408-937-2250 800-689-6669 | 408-937-2252 |

| County | CHDP Office Address | CHDP Phone | CHDP Fax |
|------------|--|--------------|--------------|
| Santa Cruz | Mail: P.O. Box 962, Santa Cruz, CA 95061 Street: 12 West Breach Street, Suite 271 Watsonville, CA 95076 | 831-763-8100 | 831-763-8410 |
| Shasta | 2650 Breslauer Way, Redding, CA 96001-4297 | 530-225-5122 | 530-225-5852 |
| Sierra | Mail: P.O. Box 7, Loyalton, CA 96118-0007 Street: 202 Front Street, Loyalton, CA 96118 | 530-993-6700 | 530-993-6790 |
| Siskiyou | 806 South Main Street, Yreka, CA 96097-3321 | 530-841-2133 | 530-841-4092 |
| Solano | 275 Beck Avenue, MS 5-175, Fairfield, CA 94533-4090 | 707-784-8670 | 707-438-2500 |
| Sonoma | 625 Fifth Street, Santa Rosa, CA 95404-4428 | 707-565-4460 | 707-565-4473 |
| Stanislaus | 830 Scenic Drive, 3rd Floor, Modesto, CA 95350 | 209-558-8860 | 209-558-8859 |
| Sutter | Mail: P.O. Box 1510, Yuba City, CA 95992-1510 Street: 1445 Veterans Memorial Circle, Yuba City, CA 95993 | 530-822-7215 | 530-822-7223 |
| Tehama | Mail: P.O. Box 400, Red Bluff, CA 96080-0400 Street: 1860 Walnut Street, Building C, Red Bluff, CA 96080-3611 | 530-527-6824 | 530-527-0362 |
| Trinity | Mail: P.O. Box 1470, Weaverville, CA 96093-1470 Street: 51 Industrial Park Way, Weaverville, CA 96093-1470 | 530-623-1358 | 530-623-1297 |
| Tulare | 1062 S. K Street, Tulare, CA 93274 | 559-687-6915 | 559-685-4701 |
| Tuolumne | 20111 Cedar Road North, Sonora, CA 95370-5939 | 209-533-7414 | 209-533-7406 |
| Ventura | 2240 East Gonzales Road, Suite 270, Oxnard, CA 93036-8210 | 805-981-5291 | 805-658-4505 |
| Yolo | 137 North Cottonwood Street, Suite 2200 Woodland, CA 95695 | 530-666-8249 | 530-666-1809 |
| Yuba | 5730 Packard Avenue, Suite 100, Marysville, CA 95901-7117 | 530-749-6366 | 530-749-6397 |

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 changes in Medi-Cal
- Understand *Treatment Authorization Request* (TAR) requirements
- Discuss oxygen services
- Identify “By Report” attachment requirements
- Understand repair and maintenance policy
- Prevent common denials

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

Provider Manual References

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

Part 2

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

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

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

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

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

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

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

ICD-10 Implementation Billing Guide

The *ICD-10 Implementation Billing Guide* can be found on the ICD-10 page of the Medi-Cal website (www.medi-cal.ca.gov).

Acronyms

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

Program Coverage

Medi-Cal covers DME when provided on a written prescription of a licensed practitioner, within the scope of the practitioner's practice, as defined by California laws.

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.

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

2016 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
 - New ventilator codes as of October 1, 2016
- Changes are date-of-service driven
- NCCI – National Correct Coding Initiative
- Medi-Cal must follow Medicare frequency limits
- New wheelchair coverage criteria to provide clarification for wheelchairs and applicable seating and positioning components

Policy Clarification and Changes

Wheelchairs and Accessories

A new section regarding wheelchairs and wheelchair accessories, *Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines* (dura wheel guide), has been added to the Part 2 provider manual. For required information for wheelchairs on TARs, refer to the *Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories* (dura bil wheel) section in the appropriate Part 2 provider manual.

Rental Reimbursement Cap Is Approved

When previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and no further reimbursement to the provider shall be made unless repair or maintenance of the item is separately authorized. When the Department of Health Care Services (DHCS) determines it is medically necessary to purchase an unlisted item of Durable Medical Equipment that had been rented for a Medi-Cal patient, DHCS and the provider shall determine the purchase price and the amount of the rental charges that may be applied to the purchase price.

Fixed Height Hospital Bed

Recipients must meet at least one of the following criteria for fixed height hospital beds:

- Positioning of body is not feasible in non-hospital beds.
- Recipient needs promotion of body alignment to prevent contractures and has a history of contractures or a documented medical condition that causes risk of contractures.
- Recipient needs alleviation of pain with a documented history of such pain related to positioning.
- Recipient needs avoidance of respiratory infections with a documented history of respiratory infection related to positioning.
- Recipient needs elevation of the head of the bed more than 30 degrees due to certain medical conditions such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or documented history of aspiration.
- Recipient needs use of special attachments or traction equipment.

4 Durable Medical Equipment

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.

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.

NOTES

Product Classification

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

| 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.

CCS-Only Benefits

The following Healthcare Common Procedure Coding System (HCPCS) codes are not Medi-Cal benefits and must be approved through the California Children's Services (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.

| Code | Description |
|-------|--|
| E0482 | Cough stimulating device, alternating positive and negative airway pressure |
| 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.

Billing

DME Modifiers

| Modifier | Description |
|----------|---|
| NU | New equipment |
| RR | Rental |
| RB | Replacement as part of repair |
| KC | Replacement of special power wheelchair interface |
| QE | Prescribed amount of oxygen is less than one liter per minute (LPM) |
| QF | Prescribed amount of oxygen exceeds four LPM and portable oxygen is prescribed |
| QG | Prescribed amount of oxygen is greater than four LPM (and portable oxygen is <u>not</u> prescribed) |
| SC | Medically necessary service or supply (used for second unit of oxygen content) |
| LT | Left Side |
| RT | Right Side |

Tax

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.

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

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* (tar comp) section 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/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* (dura bil wheel) section in the appropriate Part 2 provider manual for information.

Equipment

New Ventilator Codes

These codes replace the previous ventilator codes, effective October 1, 2016.

- E0465: Home ventilator, any type, used with invasive interface
- E0466: Home ventilator, any type, used with non-invasive interface

Oxygen/Respiratory Therapy

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:

- A7005 (administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable) – 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:

| | |
|---------|---------------|
| 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: 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

| Modifier | Oxygen Flow Rate | Reimbursement Rate |
|----------|---|---|
| RR | 1 – 4 LPM | \$144.74 |
| QE | < 1 LPM | \$72.37 <i>(reduced by 50 percent)</i> |
| QF | > 4 LPM Portable oxygen is prescribed | \$217.11 <i>(increased by 50 percent)</i> |
| QG | > 4 LPM Portable oxygen is <u>not</u> prescribed | \$217.11 <i>(increased by 50 percent)</i> |

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 first and last name of the technician
 - The title of the technician. 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: 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 invoice, plus 67 percent markup, or
- The billed amount

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

Claim Requirements for Unlisted DME Non-Wheelchairs

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

Reimbursement Conditions

Reimbursement will be the lesser of:

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

“By Report” Attachment Exceptions

- 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 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/respiratory equipment
 - K0740: oxygen/respiratory equipment
- 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 RB and NU) 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 RB and NU for replacement of wheelchair parts.

For example: E2211RBNU Pneumatic tires
K0739 Labor

Non-Wheelchairs

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

- Box 19: Statement that the equipment is owned by the patient, e.g. "Repair of patient-owned patient lift E0630"
- Description of service provided
- Reason/justification for repair
- Manufacturer's name
- List of parts used, including catalog numbers and cost for "By Report" items

For example: E0630RB Patient Lift
K0739 Labor

Oxygen/Respiratory

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

- Box 19: Statement that the respiratory equipment is owned by the patient, e.g. "Repair of patient-owned continuous positive airway pressure (CPAP) – E0601"
- 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: E0601RB CPAP
K0740 Labor

DME Common Denials

Remittance Advice Details

| Code | Description |
|------|---|
| 0002 | The recipient is not eligible for benefits under the Medi-Cal program or other special programs. |
| 0005 | The service billed requires an approved TAR (<i>Treatment Authorization Request</i>). |
| 0225 | Incorrect procedure code and/or modifier. |
| 9654 | Copy of both MSRP catalog and manufacturer's invoice are required. |
| 9098 | The attached documentation is invalid. |
| 9713 | Date on catalog or invoice is missing or invalid. |
| 9598 | Statement of "patient owned" and specific procedure code or description is missing. |
| 9719 | Amount paid by the provider is zero, no payment due. |
| 9702 | Procedure code is not payable without an invoice. |
| 9051 | Indicate the quantity per box/es on the invoice. |
| 9217 | Indicate a line number next to the catalog numbers or line on the invoice. |
| 9019 | Information on the claim does not match what is being billed. |
| 9056 | Indicate poor control, if trainable, and if for home use. |
| 9942 | NCCI (National Correct Coding Initiative) quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity. |

NOTES

Acronyms

| | |
|-----------------------|--|
| BIC | Benefits Identification Card |
| CCR | California Code of Regulations |
| CCS | California Children's Services |
| CHDP | Child Health and Disability Prevention |
| CMC | Computer Media Claims |
| CRTS | Certified Rehabilitation Technology Supplier |
| DHCS | Department of Health Care Services |
| DHCS 4073 Form | CHDP Program Pre-Enrollment Application |
| DME | Durable Medical Equipment |
| EVC | Eligibility Verification Confirmation |
| FI | Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program |
| FIG | Federal Income Guidelines |
| FQHC | Federally Qualified Health Center |
| HF | Healthy Families |
| IHS | Indian Health Services |
| LPM | Liters Per Minute |
| MNIHA | Medicare Necessary Interperiodic Health Assessment |
| MSRP | Manufacturer's Suggested Retail Price |
| MUE | Medically Unlikely Edit |
| NCCI | National Correct Coding Initiative |
| NF | Nursing Facility (Level A or B) |
| NPI | National Provider Identifier |
| OT | Occupational Therapist |
| PM 160 | Confidential Screening/Billing Report (standard and information-only) |
| POS | Point of Service |
| PPO | Preferred Provider Organization |
| PRO | Provider Relations Organization |
| PT | Physical Therapist |
| RAD | Remittance Advice Details |

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| RESNA | Rehabilitation Engineering and Assistive Technology Society of North America |
| RHC | Rural Health Clinic |
| SAR | Service Authorization Request |
| SOC | Share of Cost |
| TAR | Treatment Authorization Request |
| TSC | Telephone Service Center |