Medi-Cal Provider Training 2016

Pharmacy Billing: Home Infusion, Compound Drugs & Medical Supplies

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!

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Home Infusion and Compound Drugs

Introduction

Purpose

The purpose of this module is to provide an overview of billing procedures for paper and electronic claim submissions for home infusion and compound drug claims.

Module Objectives

- Provide information resources
- Understand billing requirements for electronic and paper compound drug claim submissions
- Prevent common denials
- Discuss changes in Medi-Cal

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

Part 2

Compound Drug Pharmacy Claim Form (30-4) Completion (compound comp)

- Provides detailed instruction on how to submit the paper claim

Compound Pharmacy Claim Form (30-4) Examples (compound ex)

- Provides samples of paper claim submissions, including:
  - Compounded intravenous prescription
  - Compounded drug with more than 25 ingredients

Pharmacy Claim Form (30-1): Special Billing Instructions (pcf30-1 spec)

Drugs: Contract Drugs List Introduction (drugs cdl intr)

- Provides the Medi-Cal formulary

Reimbursement (reimbursement)

Medi-Cal Website

From the Medi-Cal home page (*www.medi-cal.ca.gov*), click on the “Publications” tab:

- Select “Provider Manuals” and scroll down to “Pharmacy” to access the pharmacy provider manuals, or
- Select “Provider Bulletins” and scroll down to “Pharmacy (PH)” to access updated announcements on billing instructions and drug coverages

Program Coverage

Prescribed drugs listed on the Contract Drugs List, as well as unlisted drugs approved by authorization that require special compounding by the pharmacist, are covered by the Medi-Cal program, provided that the name, quantity and principal labeler of each ingredient are listed on the claim.

Legend drugs that are listed on the Contract Drugs List of the Part 2 provider manual are covered by the Medi-Cal program. Legend drugs not listed may be covered subject to authorization from a Medi-Cal field office consultant.

Non-legend, over-the-counter (OTC) drugs that are listed in the Contract Drugs List are covered by the Medi-Cal program. OTC drugs not listed, and not otherwise excluded, may be covered subject to authorization from a Medi-Cal field office consultant.

The maximum reimbursement for compounded prescriptions is the total of ingredient costs, professional fees and the compounding fees (reimbursement is reduced by an amount as described under “Pharmaceutical Services” in this section). See the *Pharmacy Claim Form (30-1): Special Billing Instructions* (pcf30-1 spec) section in the Part 2 provider manual for more information. The amount charged is not to exceed the charge to the general public for such prescriptions.

Claims Billing Methods

Electronic Claims

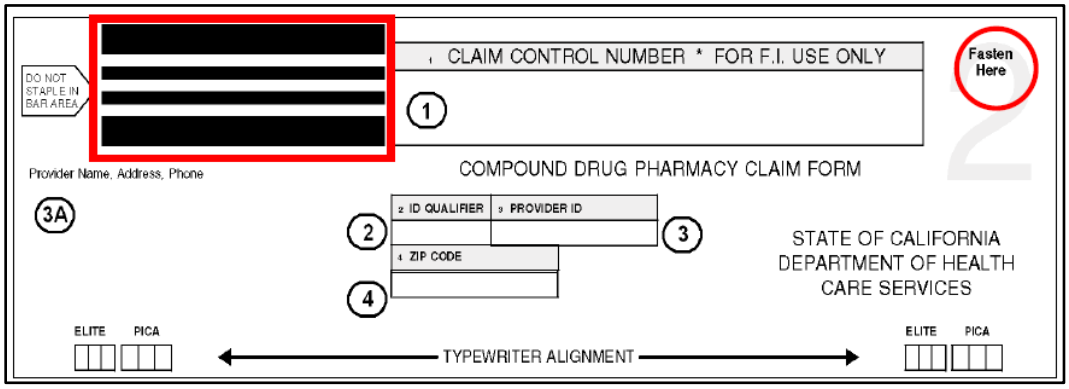
- On-Line Point of Service (POS)
- Real-Time Internet Pharmacy (RTIP)
- Advantages
  - National (NCPDP D.0) standards for claim submissions
  - Real-time, online
  - Accurate
  - Easy to process
  - Instant eligibility
  - Fast: immediate claim adjudication
  - If incorrect, claim can be resubmitted
  - No mailing cost
- Disadvantages
  - Can only bill for 25 ingredients (including the container counts)
  - May have to modify your prescription processing system
    - System vendor can find the standard rules for billing (Payer Sheet) at: (*http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/5010/20889_1_payer_sheet.pdf*)
  - Requires Internet access
  - Requires provider to be authorized to submit online claims
    - Call the Telephone Service Center (TSC) at 1-800-541-5555 for information on how to set up a *Medi-Cal Point of Service (POS) Network/Internet Agreement*
    - URL: (*www.medi-cal.ca.gov/signup.asp*), under “Pharmacy (RTIP)”

Paper (Hard Copy) Claims

- Use the Pharmacy 30-4 form for compound drug billing
  - Do <u>not</u> use the 30-1 form, which is for single ingredient billing
- To order forms, call the Telephone Service Center (TSC): 1-800-541-5555
- Advantages of using paper claims:
  - Attachments can be submitted
  - Ability to bill more than 25 ingredients
- Disadvantages:
  - Longer processing time
  - Possibility for errors to occur during the scanning process
  - Mailing cost

General rules to prevent incorrect processing or return of claims:

- Fill out the information within the allotted space for each field
- No decimal points
- No dollar ($) signs
- Use 10-point font or larger
- Keep the printer ink/ribbon full to ensure proper and readable printed information on the claim form
- Typewriter font: Elite or Pica
  - Avoid handwriting if at all possible due to potential for errors
- Computer-generated forms: Any fonts and/or font size that would allow all the information to fit into the allotted space of the fields.
- Do not interfere with the barcode area (outlined in red below) on the claim form:



- If attachments are required, ensure that staples go in the appropriate “Fasten Here” area of the claim form (circled in red above)
  - Do not skip lines
  - Do not leave blank lines or “0” quantities
  - Do not use Wite-Out or other correction fluids/materials

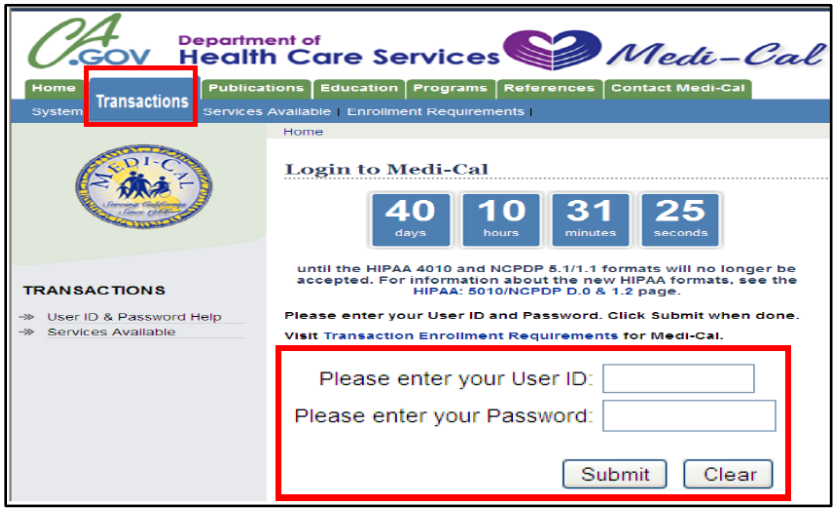
Attachments

- When compounds contain more than 25 ingredients, please list the remainder of the ingredients on a separate sheet to attach to the claim form.
- Do NOT attach the following:
  - TAR approvals or request forms
  - Catalog pages for items with NDC numbers
  - Prescription copies, order sheets, etc.

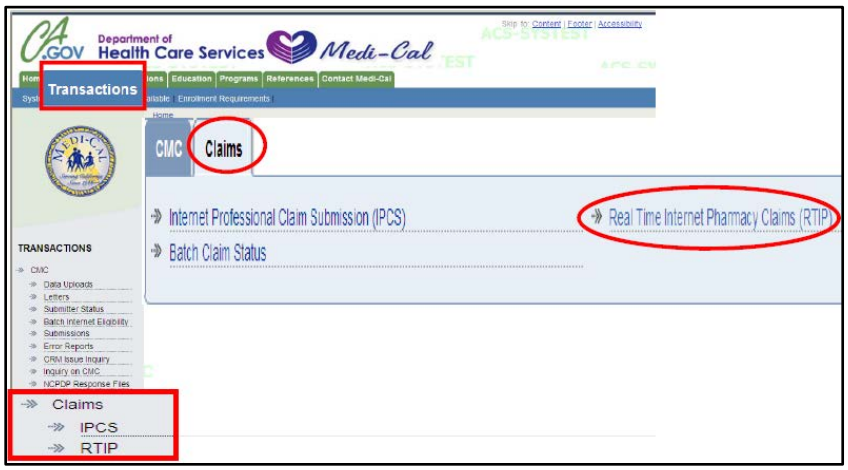
RTIP (Online Claim Submission)

The following provides step-by-step instructions for submitting a compound claim through Real-Time Internet Pharmacy (RTIP).

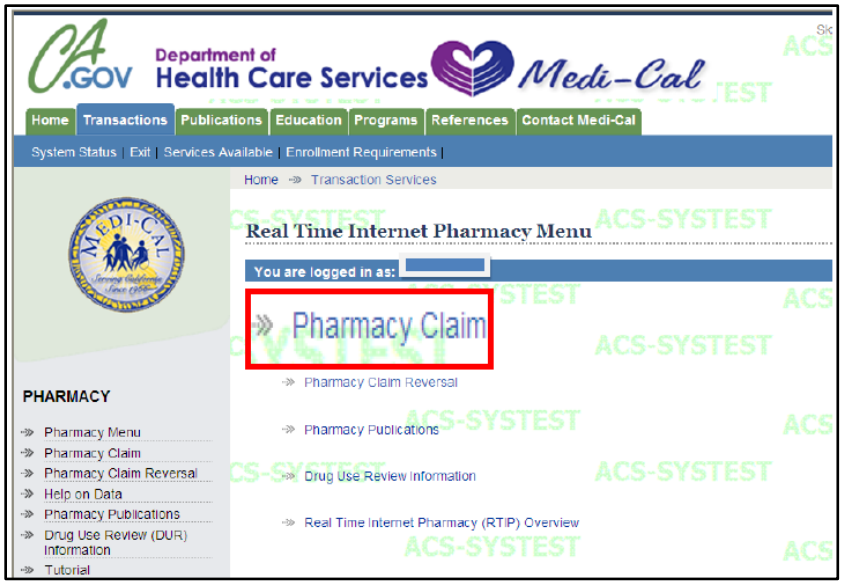
1. On the home page of the Medi-Cal website (*www.medi-cal.ca.gov*), click the "Transactions" tab to access the login screen for RTIP:



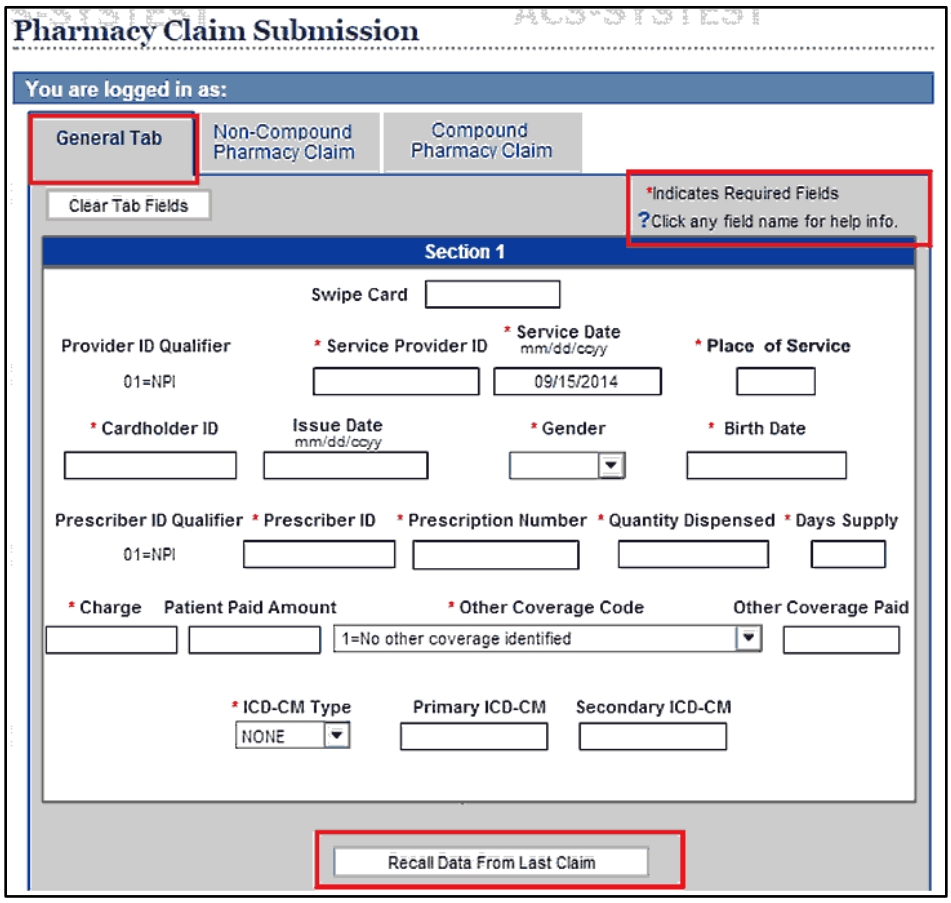
2. On the "Claims" tab, select "RTIP":



3. Select “Pharmacy Claim”:



4. Start with the “General Tab” to fill in all the required information and any optional data for the claim submission:



a. Any fields designated by "*" require information for the claim submission.

b. On any field, help information is available by placing the mouse over the field title and left-clicking. A small help screen will appear with a definition of the field data.

c. The "Recall Data From Last Claim" button is helpful if you are submitting multiple claims for a single patient. The system re-populates pertinent/required information, eliminating the need to re-type data in each field.

d. The "Clear Tab Fields" button clears all form fields in one step.

e. **Provider ID Qualifier:** Only a 10-digit NPI will be accepted. Do not submit claims using a Medicare provider number or state license number. You must enter this information for your claim to process successfully.

f. **Service Date:** Enter the date the prescription was filled in eight-digit MMDDYYYY (Month, Day, Year) format (for example, January 6, 2015 = 01062015). Do not bill Medi-Cal until the patient or a representative of the patient has received the prescription. You must enter this information for your claim to process successfully.

g. **Place of Service:** Enter a valid two-digit code that represents Place of Service location. Refer to the Department of Health Care Services (DHCS) California Medicaid Management Information System (CA-MMIS) *NCPDP Standard Payer Sheet*, field number 307-C7 for a list of valid Place of Service codes. You must enter this information for your claim to process successfully.

   - Examples of codes:
     12 = Home
     13 = Assisted Living Facility
     14 = Group Home
     20 = Urgent Care Facility
     21 = Inpatient Hospital
     22 = Outpatient Hospital
     23 = Emergency Room
     24 = Ambulatory Surgical Center
     31 = Skilled Nursing Facility
     32 = Nursing Facility
     33 = Custodial Care Facility
     34 = Hospice
     54 = Intermediate Care

h. **Cardholder ID:** Enter the 9, 10 or 14-character recipient ID number as it appears on the Benefits Identification Card (BIC). You must enter this information for your claim to process successfully. A Social Security Number (SSN) is not allowed for billing.

i. **Issue Date:** Enter the Issue date on the Benefits Identification Card (BIC) in MMDDYYYY (Month, Day, Year) format. This information is required if an ID other than the 14-character BIC ID is entered in the Cardholder ID field.

j. **Prescription Number:** Enter your prescription number in this space for reference on the *Remittance Advice Details* (check warrant and voucher). A maximum of 12 digits may be used. You must enter this information for your claim to process successfully.

k. **Quantity Dispensed:** Enter the total quantity dispensed. Do not include measurement units such as Gm, CC or ML. Enter the quantity in 9999999.999 format. You must enter this information for your claim to process successfully. Providers are reminded that the quantity should represent the metric measurement of the actual compounded product dispensed. If the dispensed amount is liquid, then the value should represent the amount in milliliters (mL). If the product dispensed is a cream or ointment, the value should represent the amount in grams (G). If the product dispensed is a capsule or tablet or suppository, the value should represent each unit (E). Providers are also reminded that the quantity dispensed represents the total amount dispensed. For example, if the quantity dispensed is seven bags containing 110mL per bag, the quantity dispensed should be 770mL.

l. **ICD-CM Type:** Enter the ICD code type. The following values are available in this field:

- NONE
- ICD-9
- ICD-10

Users should choose “NONE” only if the claim does not require an ICD code in the *Primary Diagnosis Code* field. The value “NONE” is the default value.

Users choosing “ICD-10” are required to enter an ICD-10 code in the *Primary Diagnosis Code* field. The *Secondary Diagnosis Code* field is optional, but any secondary code entered must be an ICD-10 code.

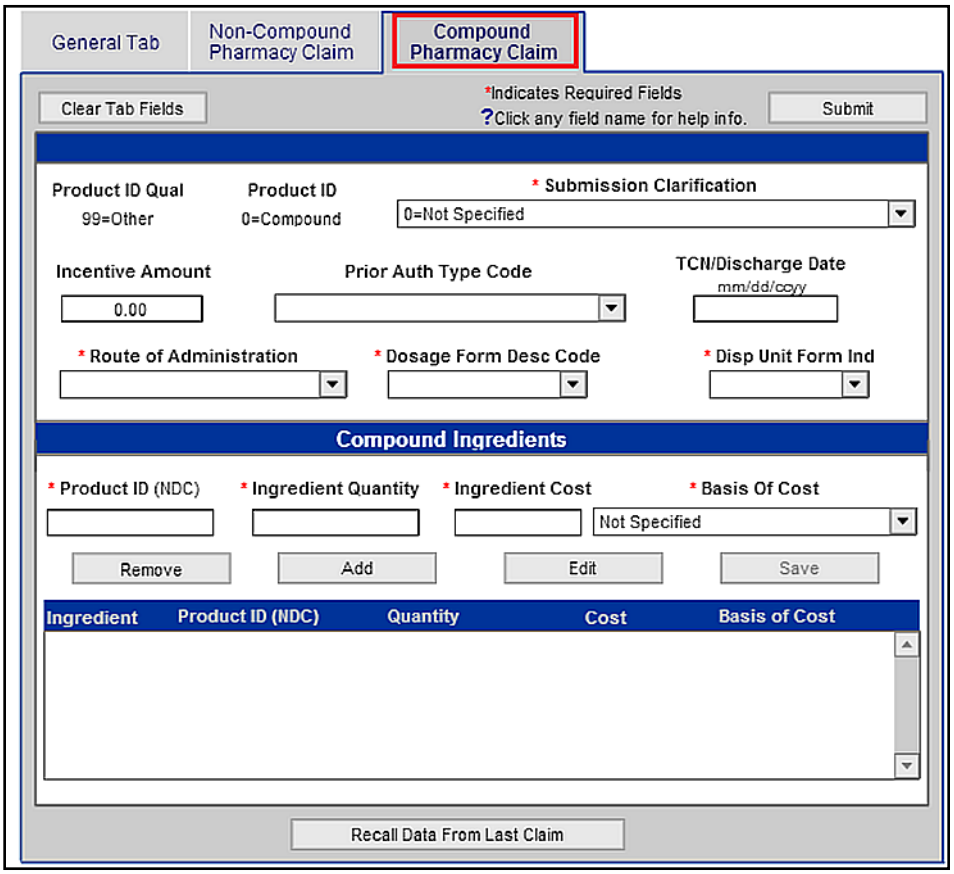
m. **Charge:** Enter the dollar and cents amount for this item, including the decimal point (.) to show cents, but not including a dollar ($) sign. If the item is taxable, include the applicable state and county sales tax. Compounding, professional and sterility testing fees should be included in this total. You must enter this information for your claim to process successfully.

n. **Patient Paid Amount:** Enter the full dollar amount of the patient's Share of Cost (SOC) for the procedure, service or supply. Include the decimal point (.) when indicating cents. Do not include a dollar ($) sign. Leave blank if not if applicable. For more information, see the *Share of Cost (SOC): 30-1 for Pharmacy* section of the Part 2 provider manual.

o. **Other Coverage Code:** Select the appropriate code that indicates whether the patient has other insurance coverage, and if so, the extent and status of the coverage for the claim being submitted.

p. **Other Coverage Paid:** Enter the full dollar amount of payment received from other coverage carriers. Use the decimal point (.). Leave blank if not applicable.

5. Select the “Compound Pharmacy Claim” tab and continue to fill in the required fields and any additional/optional claim information:



a. **Submission Clarification:** Select 7 (Medically Necessary) if the drug is subject to Code 1 restrictions and these restrictions have been met. Select 8 (Process for Approved Ingredients) if you would like the claim to be processed even if all of the ingredients are not covered by Medi-Cal. Ingredients that are not covered will be paid zero. Select 99 (Other) if Code 1 is met AND you would like the submission to be processed for approved ingredients only. Select 00 (Not Specified) if not applicable. You must enter this information for your claim to process successfully.

b. **Incentive Amount:** Enter the sterility test fee, if sterility testing was performed. Include the decimal point (.) when indicating cents. This field is not required.

c. **Prior Auth Type Code:** Select the appropriate code that indicates whether authorization or a payer-defined exemption (discharge date) is required. This field must be selected if a TAR control number or a discharge date is included on the claim.

d. **TCN/Discharge Date:** If, in the “Prior Authorization Type Code” selection box, 1=Prior Authorization (TAR) is selected, then the TAR control number is required. Enter the 11-digit TAR control number from the approved TAR. Recipient, quantity, drug, compound ingredients and date of service on the claim must agree with the information on the TAR. If, in the “Prior Authorization Type Code” box, 8=Payer Defined Exemption (Discharge Date) is selected, then enter the discharge date in MMDDYYYY format. If the date of service is 10 days or less from the discharge date, then certain I.V. products that require a TAR will be payable without a TAR.

e. **Route of Administration:** Select the appropriate code that describes the way the complete compound mixture will be administered. You must enter this information for your claim to process successfully. Codes include:

01: Buccal	12: Other/Miscellaneous
02: Dental	13: Otic
03: Inhalation	14: Perfusion
04: Injection	15: Rectal
05: Intraperitoneal	16: Sublingual
06: Irrigation	17: Topical
07: Mouth/Throat	18: Transdermal
08: Mucous Membrane	19: Translingual
09: Nasal	20: Urethral
10: Ophthalmic	21: Vaginal
11: Oral	22: Enteral

f. **Dosage Form Desc Code:** Select the appropriate code that describes the dosage form for the complete compound mixture. You must enter this information for your claim to process successfully.

01: Capsule	11: Solution
02: Ointment	12: Suspension
03: Cream	13: Lotion
04: Suppository	14: Shampoo
05: Powder	15: Elixir
06: Emulsion	16: Syrup
07: Liquid	17: Lozenge
10: Tablet	18: Enema

g. **Disp Unit Form Ind:** Select the appropriate NCPDP standard unit of measure for the final compound mixture.

- Manufactured capsules, tablets, powder vials are measured as **each (E)**.
- Ointments, creams and dry products, such as powders, are measured in **grams (G)**.
- Liquids, including injections, are measured in **milliliters (M)**.

h. **Product ID (NDC):** Enter the National Drug Code (NDC). All NDC numbers must be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into three segments. For a complete 11-digit number, the first segment must have five digits, the second segment four digits and the third segment two digits. Add leading zeroes wherever they are needed to complete a segment with the correct number of digits. To bill for containers, use product ID 99999999997.

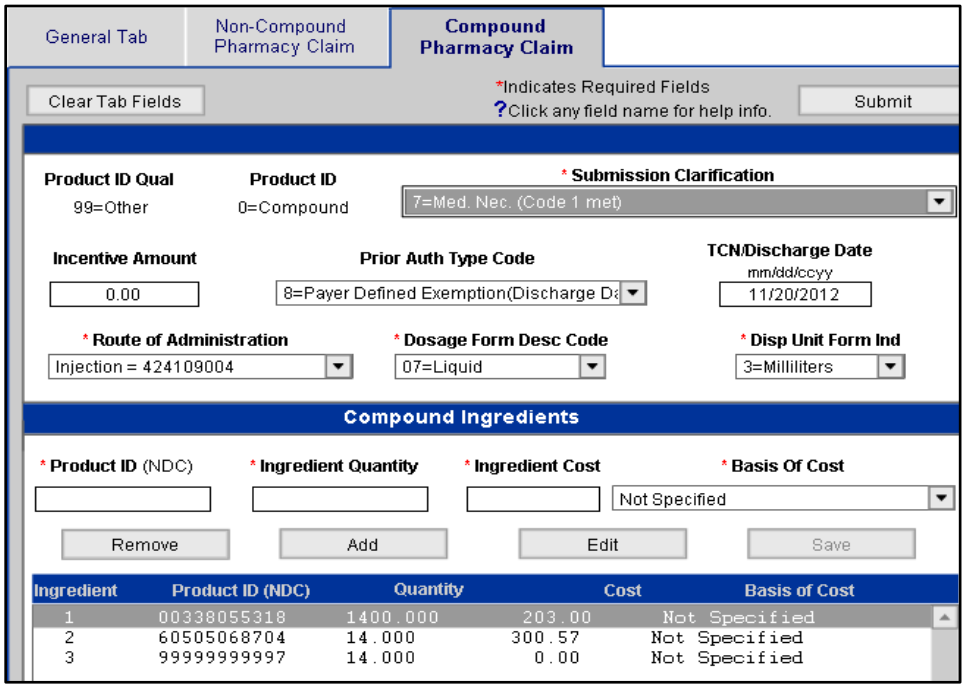
i. **Ingredient Quantity:** Enter the amount of the product included in the compound mixture, expressed in metric decimal units. Enter the quantity in 9999999.999 format. When indicating the number of containers (with product ID 99999999997), enter a whole number less than 1000.

j. **Ingredient Cost:** Enter the ingredient cost for the metric decimal quantity of the product included in the compound mixture indicated in “Compound Ingredient Quantity.”

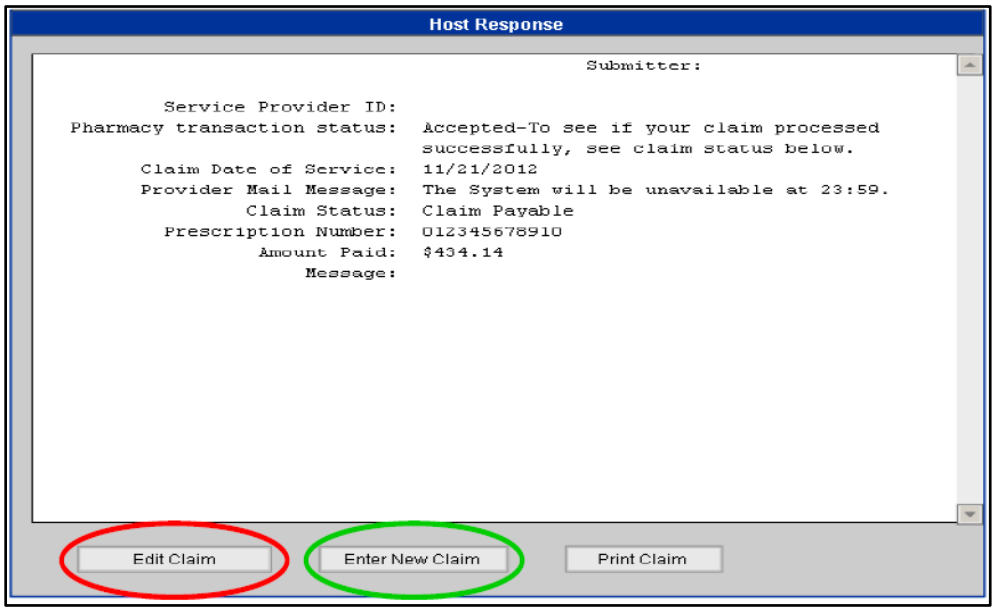
k. **Basis of Cost:** This field indicates the method by which the ingredient cost was calculated. Select “08=Disproportionate Share/Public Health Service” if the cost basis is Disproportionate Share/Public Health Service; otherwise, select the default value of “00=Not Specified.” You must enter this information for your claim to process successfully.

6. Hit “Submit” when all fields for the claim have been filled out.

7. Examples of a Compounded Intravenous Prescription:

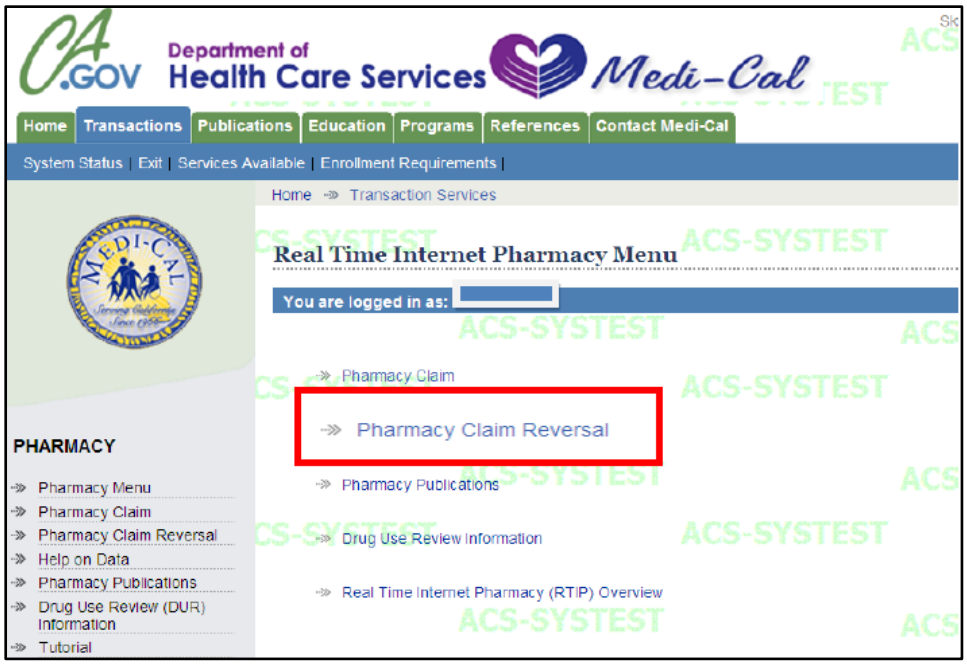


8. After selecting “Submit”: Review the message for successful claim adjudication by reviewing the amount paid on the Host Response screen. If the claim payment is unacceptable due to a possible error, the claim can be edited for re-submission by selecting “Edit Claim.” If the claim payment is as expected, move on by selecting “Enter New Claim.”



9. Pharmacy Claim Reversal

   a. Select the “Pharmacy Claim Reversal” option (below the “Pharmacy Claim” option):



   b. Select “Recall Data from last Transaction”:

   c. For reversing a compound claim in RTIP, use “0” for the Product ID. This is the NCPDP product ID value to indicate a compound drug.

Paper Claim (Pharmacy 30-4 Claim Submission)

For most fields on the paper claim, the required data is the same as for RTIP billing. There are only a few differences to note:

Prescription Number

- RTIP: Prescription number is 12 bytes/digits
- 30-4 paper claim form, box 10: Prescription number is 7 bytes/digits

Code 1 Restriction

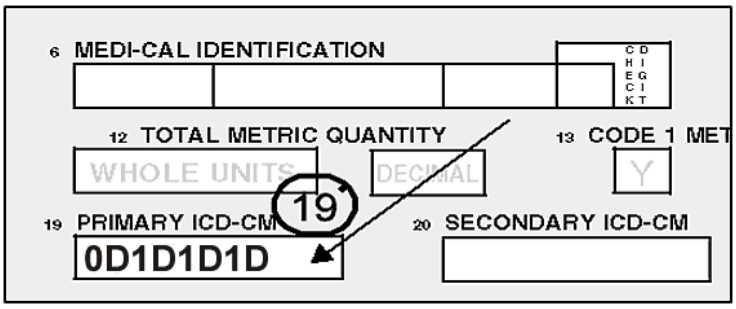
- RTIP: Option 07 (Medically Necessary) under Submission Clarification is used to indicate the Code 1 restriction has been met. Please refer to the Submission Clarification entry discussed earlier in the billing section.
- 30-4 paper claim form, box 13: Indicate “Y” (yes) if the Code 1 restriction for the drug has been met.

Patient Location

- RTIP: This field is required. Information must be entered in order for the claim to be processed successfully.
- 30-4 paper claim form, box 15: This is an optional field. If the field is blank, the system calculates the professional fee at $7.25. If the patient resides in a Nursing Facility as described below, and this is indicated on the claim, the professional fee will be $8.00.
- If the patient resides in a Nursing Facility, select one of the following codes:
  C = Nursing Facility (NF) Level A
  4 = Nursing Facility (NF) Level B
  F = Nursing Facility (NF) Level B (Adult Subacute)
  F = Subacute Care Facility
  G = Intermediate Care Facility – Developmentally Disabled (NF-A/DD)
  H = Intermediate Care Facility – Developmentally Disabled, Habilitative (NF-A/DD-H)
  I = Intermediate Care Facility – Developmentally Disabled, Nursing (NF-A/DD-N)
  M = Nursing Facility Level B (Pediatric Subacute)

Primary ICD-CM

- RTIP: The information for this field is dependent on the option chosen for the *ICD-CM Type* field. Review the “RTIP (Online Claim Submission)” section above regarding ICD type and Primary ICD codes.
- 30-4 paper claim form, box 19: This field is optional. Unlike RTIP, there is no separate field for ICD-CM type indication. Providers must input an ICD indicator (“0”) as the first digit in the field with no spaces or dashes separating it from the diagnosis code. Enter ICD indicator “0” followed by an ICD-10 code.

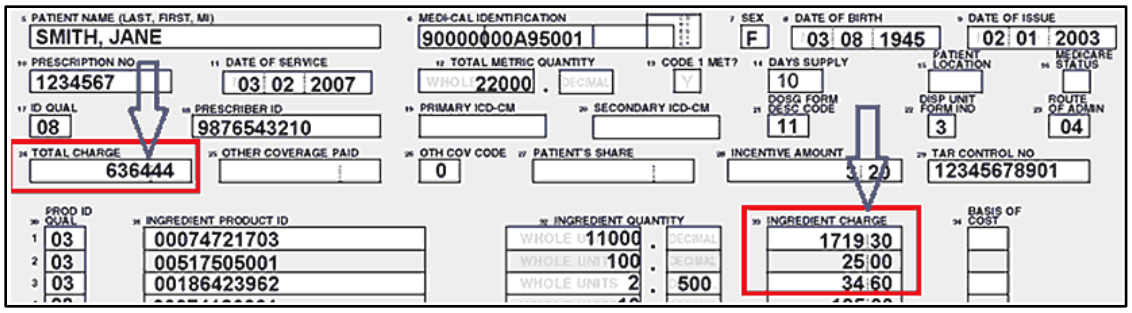


Secondary ICD-CM

- RTIP: The information for this field is dependent on the option chosen for the *ICD-CM Type* field. Review the RTIP section regarding ICD type and Secondary ICD codes.
- 30-4 paper claim form, box 20: This field is optional, no ICD indicator is required in the *ICD-CM* field. If ICD indicator “0” is in the *Primary ICD-CM* field, then an ICD-10 code must be utilized for this field.

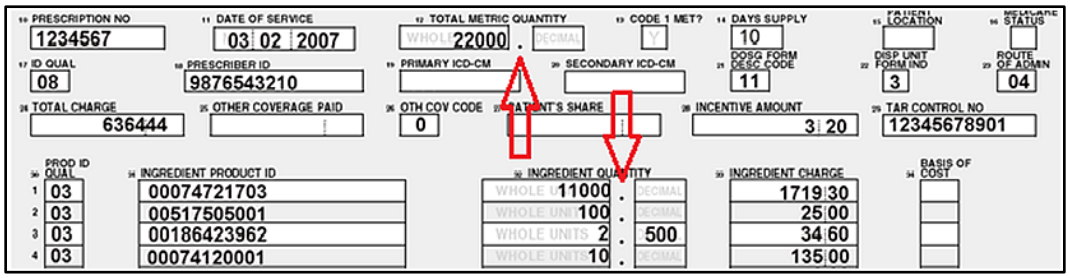
Total Charge, Ingredient Charge, Incentive Amount, and Patient Paid Amount

- RTIP requires a decimal (.) between dollars and cents; i.e., $324.19. If there is no decimal, then the system adds “.00”; i.e., $32419.00. Do not enter a dollar ($) sign on RTIP or on a paper claim.
- 30-4 paper claims do not require decimals to differentiate between dollars and cents. There is a field separation pre-printed on the form to distinguish the difference:



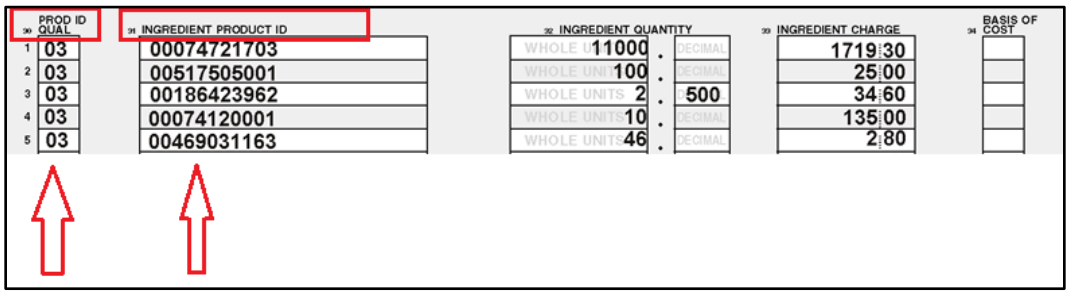
Quantity Dispensed and Ingredient Quantity fields

- RTIP requires quantity in 9999999.999 format, including the decimal point.
- 30-4 paper claims do not require a decimal to differentiate between a whole number and tenths or hundredths. The fields already have a decimal pre-printed on the form:



Ingredient Product ID Qualifier

- RTIP does not require a value
- 30-4 paper claims require a code to indicate type of ingredient to be entered in field 31:

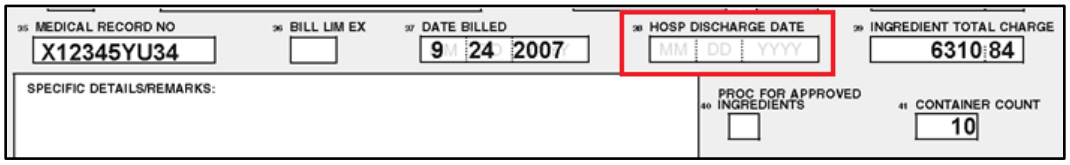


- Example of values:

Code	Explanation
1	Universal Product Code (UPC)
3	National Drug Code (NDC)
4	Universal Product Number (UPN)
99	Other

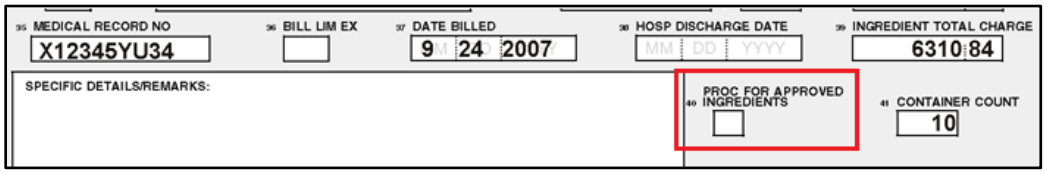
Hospital Discharge Date

- RTIP: Please refer to the TCN/Discharge date field entry as discussed earlier in the billing section.
- 30-4 paper claim, box 38: This is the field to enter the hospital discharge date, if applicable:



Processed for Approved Ingredient

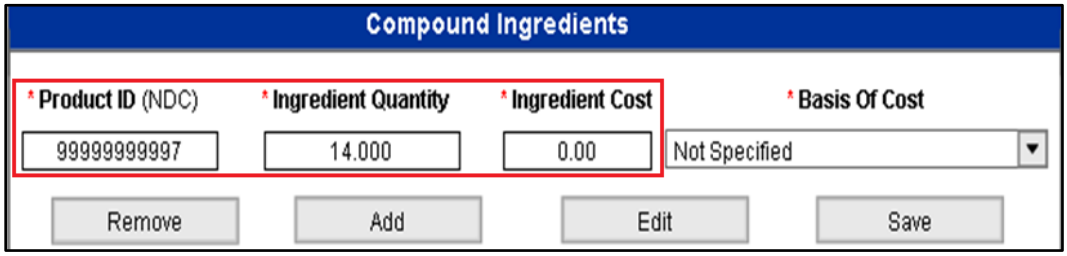
- RTIP: Please refer to the “Submission Clarification” field entry as discussed earlier in the billing section.
- 30-4 paper claim, box 40: Enter “Y” to process for approved ingredients only. If a “Y” is entered in this field, approved ingredients will be reimbursed, but ingredients not on the list of contract drugs will be paid at $0. If this field is left blank, any ingredient that requires authorization will cause the claim to be denied. If the compound contains inexpensive ingredients that would not be worth getting authorization for, the provider may want to use this field to expedite payment of the claim.



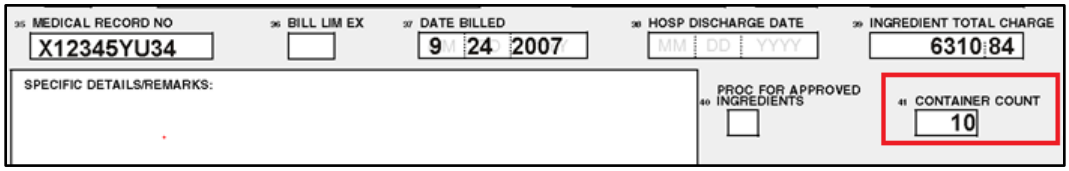
Container Count

A *Treatment Authorization Request* (TAR) is required when more than 20 containers are billed for I.V. claims.

- RTIP: For intravenous (I.V.) compound claims, indicate the number of containers by entering a product ID of "99999999997" and the number of containers in the ingredient quantity field. The ingredient cost should be zero when indicating the number of containers.



- 30-4 paper claim, box 41: Enter the number of container counts.



Signature of Provider and Date

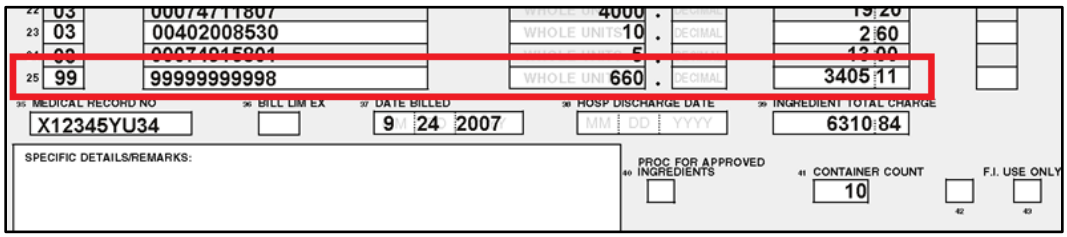
- RTIP: No signature or date is required
- 30-4 paper claim, box 45: An original signature is required on all paper claims. The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file with the Fiscal Intermediary (FI). A missing signature will result in the claim being returned.

Specific Details/Remarks

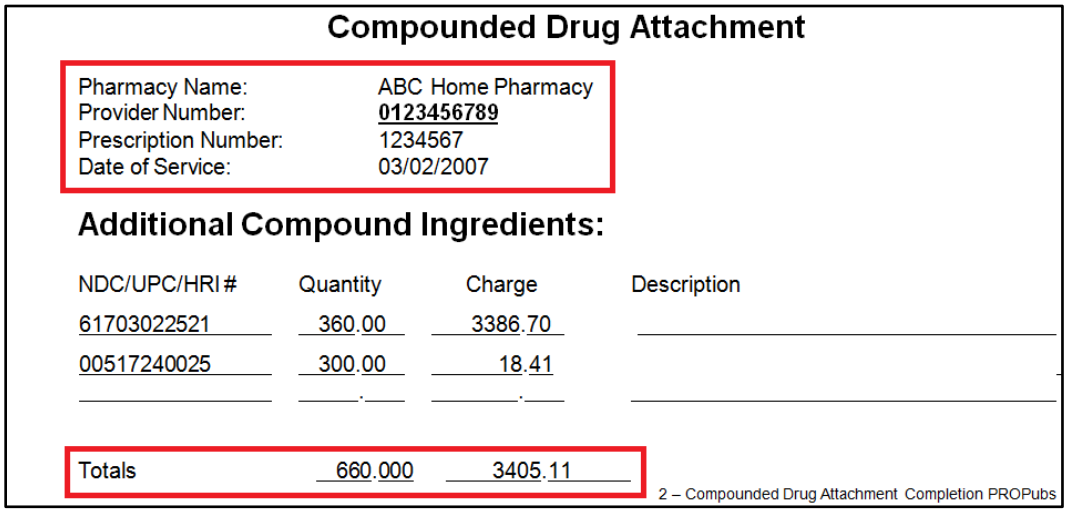
- RTIP: There is no section for details or remarks.
- 30-4 paper claim: Use this blank space to clarify or detail any line item. Indicate the ingredient line item number being referenced. The *Specific Details/Remarks* area is also used to provide information about crossovers. See the *Medicare/Medi-Cal Crossover Claims: Pharmacy Services* (medi cr ph) section of the Part 2 Pharmacy manual for more information.

More than 25 Ingredients

- RTIP: There is a limit of 25 product codes; i.e., 25 ingredients or 24 ingredients plus a product ID of "99999999997" for the container count.
- 30-4 paper claim: There are 25 lines for ingredients. If the compound contains more than 25 ingredients, then any additional ingredients will be required to be billed on an attachment.
  - The 25th billing line would require a product ID qualifier of 99 and a product ID of 99999999998. The ingredient quantity and ingredient charges would be the sum of all the remaining ingredients' quantities and charges:



  - The Compounded Drug Attachment should contain the pharmacy name, provider ID, prescription number and date of service:



Compounded Drug Attachment

Pharmacy Name: ABC Home Pharmacy
Provider Number: **0123456789**
Prescription Number: 1234567
Date of Service: 03/02/2007

Additional Compound Ingredients:

NDC/UPC/HRI #	Quantity	Charge	Description
61703022521	360.00	3386.70	
00517240025	300.00	18.41	
	.	.	
Totals	660.000	3405.11	

2 – Compounded Drug Attachment Completion PROPubs

Summary and Additional Billing Info

The **ingredient quantity** field is the sum of the amount of that ingredient that is in all containers of the compound. It is not the per-container amount. The **ingredient charge** should reflect the total charge for the ingredient in all containers of the compound. It is not the per-container amount.

Home Infusion/Compounding Drug Products Reimbursement Chart:

Item Being Billed	Reimbursement
Cost of ingredients	Paid at Estimated Acquisition Cost (EAC)
Cost of supplies consumed in compounding I.V. solution	EAC up to $5.56 per container
Cost of empty containers **Note** Empty containers must be billed separately from the compound claim.	Paid at EAC
Cost of sterility testing (only when performed)	Up to $0.32 per container
Professional fee	$7.25 per container if compounded, or $7.25 per prescription, if not compounded
Compounding fee	$0.99 per container (in addition to professional fee, for compounded solutions only) Capsules, powders, tablets, lozenges: 6-36…….$1.98 37 and over…….$3.95 Ointments and creams: 1 gm to 179 gm……..…...$1.64 180 gm and over……...$3.29 Suppositories: 1 to 23 …….$3.29 24 and over……..$5.76 Sterile eye preparations: All …….$2.04 Nose and ear preparations: All ……..……..……..…….$0.81 Emulsions, lotions: 1 cc to 239 cc…….$0.81 240 cc and over…….$1.64 Liquids other than simple pouring or reconstituting solutions, shampoos, elixirs, syrups, suspensions, enemas: All ……..…….$0.99

Maximum reimbursement for compounded prescriptions may include any or all of the following:

- Total of ingredient costs
- Professional fees
- Compounding fees

Compounding fees are paid based on the dosage form and route of administration submitted on the compound pharmacy claim. To ensure correct payment, be certain to enter the information correctly.

If the preparation is not for home infusion therapy (capsules, ointments, emulsions, etc.), only one container will be allowed and the cost of supplies, empty containers and sterility testing will not be allowed.

Add-Vantage vial or threaded port vials are not considered to be compounded products.

- Add-Vantage vial or threaded port vials must be billed as non-compound.
- If a TAR is required, then the provider must apply for the TAR as a single drug claim billing.
- If an antibiotic is a continuation drug from the hospital and requires a TAR, this cannot be overridden by the discharge date.
  - Provider must get a TAR with justification of continuation of therapy from hospital discharge.

The rule that states providers must bill within 10 days following the patient's discharge from an acute care hospital applies only when billing for compound drugs.

AIDS or cancer drugs (excluded from the six prescriptions/month limit, per the Contract Drugs List) included as part of the compound drug will also be excluded from the six prescriptions/month limit.

Medical supplies cannot be billed on the 30-4 form. They must be billed using the hard-copy *CMS-1500* claim form or via electronic format.

Effective September 22, 2014, the Department of Health Care Services (DHCS) discontinued accepting Point of Service (POS) device transactions for pharmacy claims.

Questions and Phone Tree Options

For questions, call the Telephone Service Center (TSC) at 1-800-541-5555 for a TSC agent to assist you with your billing claims needs. If the agent cannot assist you sufficiently, please contact the Provider Regional Representative assigned to your region.

TSC Main Menu Prompt Options

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

Please select from the following menu:	
Press or say 1	For the Automated Eligibility Verification System
Press or say 2	For Provider Telecommunications Network
Press or say 3	For checkwrite
Press or say 4	For Cancer Detection Programs or the Technical Help Desk, including eTAR
Press or say 5	For HAP, Family PACT, CHDP, CCS, GHPP, Crossover, LTC and other general billing inquiries
Press or say 6	For Provider Enrollment, TAR or Every Woman Counts
Press or say 7	If you are assisting a hearing impaired caller

Secondary Menu Prompt Options

Option 4	
Press or say 1	For Cancer Detection Programs
Press or say 2	For CMC, POS/Internet, eTAR, LSRS, Pharmacy/CALPOS, POS Device, CHDP Gateway, HIPAA or Hospital Presumptive Eligibility
Press or say 3	For dates and locations of Medi-Cal provider training seminars

Option 5	
Press or say 1	For HAP or Family PACT
Press or say 2	For CHDP
Press or say 3	For CCS or GHPP
Press or say 4	For Crossover
Press or say 5	For LTC
Press or say 6	For general billing
Press or say 7	For DRG billing

Option 6	
Press or say 1	For Provider Enrollment
Press or say 2	For TAR
Press or say 3	For Every Woman Counts

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

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)
Part 2: *Incontinence Medical Supplies: An Overview* (incont)
Part 2: *Medical Supplies* (mc sup)
Part 2: *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

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* and the *Incontinence Medical Supplies: An Overview* 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
- Heparin 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 contracted 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 may not 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* section of the Part 2 provider manual.

List of Contracted Advanced Wound Care Dressings

This spreadsheet contains advanced wound care 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. 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 (HCPCS)	Manufacturer	Product Description	Item Number (reference only)	UPN Qualifier	UPN	MAC and MAPC per UOM	UOM	Effective Date of Change	Publication Date
A6010	MPM Med	MPM triple helix collAgen powder 1 gm Each	MP00311	UP	366977310017	$14.00	gm	Prior to 2/16/2015	February 2015
A6010	Southwest Tech	Stimulen collagen powder bottle 10 gm Case	ST9515	UP	745713095157	$14.00	gm	Prior to 2/16/2015	February 2015
A6010	Southwest Tech	Stimulen collagen powder bottle 20 gm Case	ST9520	UP	745713095201	$14.00	gm	Prior to 2/16/2015	February 2015
A6010	Southwest Tech	Stimulen collagen powder bottle 40 gm Case	ST9540	UP	745713095409	$14.00	gm	Prior to 2/16/2015	February 2015
A6010	Southwest Tech	Stimulen collagen powder sachet 1 gm Box	ST9501	UP	745713695012	$14.00	gm	Prior to 2/16/2015	February 2015
A6021	Hartmann, USA	CollaSorb collAgen 2"x2" Box	49750000	UK	20612553018223	$3.50	ea	Prior to 2/16/2015	February 2015
A6021	Hartmann, USA	CollaSorb collAgen 4"x4" Box	49760000	UK	20612553018230	$7.50	ea	Prior to 2/16/2015	February 2015

List of Contracted Advanced Wound Care Dressings (excerpt)

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* 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* 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

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

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

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
- Heparin 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
- Heparin flush solutions
- Enteral Nutritional Formula

HCPCS Level II codes <u>cannot</u> 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													

	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 01 15		12		A4399			23 00	2		NPI
2	ON30003175507				UN0000002000						
	04 01 15		12		A4367			15 00	2		NPI
3	UP762123001493				UN0000006000						
	04 01 15		12		A4363			14 00	6		NPI
4	EN0762123010327				UN0000030000						
	04 01 15		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 04/15/15	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 F

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

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% 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% mark-up and tax (if applicable). Incontinence supplies are reimbursed at MAPC plus 38% mark-up and tax (if applicable). See the 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 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 found on the Medi-Cal website.
- Providers with a TAR/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 & C 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.

Additional Billing Tips

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

- A4322 – Irrigation syringe, regardless of how used (ex: used for feeding or irrigation 50 ml and over, common size 60 ml) when billing attachment does not describe the item otherwise.
- 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.
- B9999 – Empty I.V. bags, I.V. catheters, PICC supplies
- A4212 – Huber needles
- A4215 – Pen needles
- A4628 – Yankauers
- J1731 – Hypertonic saline solution, 1 ml (TAR required). Submit TARs to the Sacramento Field Office.
- T5999 – Decompression tubes, Peristeen Anal Irrigation
- A9274 – Omni Pods

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

For electronic claims, when entering additional information in box 19, only 80 bytes will be accepted. 81 bytes will cause the claim to be rejected.

Certain charges appearing on invoices may not be billable to the Medi-Cal program. Providers are required to include the following certification statement written exactly as shown for any printout of an electronic invoice or invoice attachment containing statements that mention hidden charges or added charges, fees or cost to invoice prices:

> "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 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 date of service (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% mark-up

Incontinence Supplies*

1-each (or gram, milliliter, etc.) cost x quantity x tax rate (if applicable) x 38% mark-up
* When AWP, SWP or SWR pricing is used for pricing, the calculation is reduced by 5%

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

- Provider must include the published contracted UPN on the claim in the appropriate section.
- 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 requires a TAR.
- Non-contracted disposable products meeting the descriptions listed below require a TAR. Claims must include documentation of product cost (invoice, manufacturer catalog page or price list) as an attachment to the claim.

HCPCS Code	Description (Non-Contracted Supplies)
A4520	Incontinence garment, any type, each, not elsewhere classified
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

- Protective underwear/pull-ons are approved for independence in toileting or for toilet training/habit training programs. Providers must include a treatment plan and progress report or narrative on prescription, including the toilet training success percentage, number of successes, and number of times toileted. The utilization limit is 120 per month.
- 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, and/or 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-DDH 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 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. The utilization limit is 120 per month. 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, Diagnosis 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 program. 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

New prescriptions are required each year. When a prescription expires, a new one must be requested for billing.

Medicare Coverage for Medical Supplies

Medicare coverage for medical supplies can be found in the *Medical Supplies* 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 resuscitator 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: *Medical Supply Products: Tracheostomy*, *Medical Supply Products: Miscellaneous*, *Medical Supply Products: Ostomy – Accessories/Skin Barriers* and *Medical Supply Products: Urologicals – Insertion Trays*. Providers may also contact the Telephone Service Center (TSC) at 1-800-541-5555.

Medical Supplies Common Denials

RAD Code	Reason RAD Description	Billing Tips
0005	The service billed requires an approved TAR *(Treatment Authorization Request).*	1. Procedure code requires a TAR. 2. The quantity and frequency limits have been exceeded. 3. 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.
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.

RAD Code	Reason RAD Description	Billing Tips
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.
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.
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.

Acronyms

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
CMC	Centers for Medicare & Medicaid Services
CSU	Correspondence Specialist Unit
DHCS	Department of Health Care Services
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-9	International Classification of Diseases – 9th Revision
ICD-10	International Classification of Diseases – 10th Revision
LTC	Long Term Care
LSRS	Lab Service Reservation System
MAC	Maximum Allowable Product Cost
MAPC	Maximum Allowable Product Cost
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
POS	Point of Service
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