

Prescription Referrals

This section describes prescription requirements for therapeutic services, orthotic and prosthetic (O & P) appliances and Durable Medical Equipment (DME) rentals and purchases.

Prescription Requirements for Speech Therapy, Physical Therapy, Occupational Therapy and Audiology

The written prescription of a licensed practitioner, acting within the scope of his or her practice, is a requirement of the Medi-Cal program for coverage of services by physical therapists, occupational therapists, speech pathologists and audiologists.

Medical Necessity

With the passage of AB1074 (1985), the Medi-Cal program 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.

It is important that the practitioner prescribing services supply the therapist with the information required to document the medical necessity for the services according to the above criteria.

Required Information

In addition to the signature of the practitioner, the following information must be supplied on the prescription form:

- Name, address and telephone number of the prescribing practitioner
- Date of prescription
- Medical condition necessitating the service(s)
- Supplemental summary of the medical condition or functional limitations (may be attached to the prescription)
- Specific services (for example, evaluation, treatments, modalities) prescribed
- Duration of medical necessity for services (Specific dates and length of treatment should be provided if possible. Duration of therapy should be set by the prescriber, but a prescription should extend no longer than six months.)
- Anticipated medical outcome as a result of the therapy

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Prior Authorization	When prior authorization is required, as for services in a rehabilitation center or in a Long Term Care facility, a copy of the prescription itself must accompany the <i>Treatment Authorization Request</i> (TAR) submitted to the Medi-Cal field office and must contain all the preceding information.
Specific Prescription Requirements for Speech Therapy	As appropriate, the following data regarding the recipient should be included on each prescription: <ul style="list-style-type: none">• Age• Developmental status and rate of achievement of developmental milestones• Mental status and ability to comprehend• Related medical conditions
Purpose of Speech Therapy	The goal of therapy should be achievement of intelligibility rather than age-specific qualities or previous condition status (such as with a stroke victim).
Specific Prescription Requirements for Physical Therapy	Prescriptions should be as specific as possible regarding procedures, modalities and services. For example, “physical therapy” alone is not a sufficient notation on the prescription. A specified duration of therapy should be indicated in weeks or months.
Purpose of Physical Therapy	The purpose of therapy should be the return of adequate function, not necessarily restoration of full capacity.

Specific Prescription
Requirements for
Occupational Therapy

As appropriate, prescriptions should include the following information regarding the recipient:

- Age
- Functional limitations
- Mental status and ability to comprehend
- Related medical conditions
- Delay in achievement of developmental milestones in a child or impairment of normal achievement in an adult

Purpose of
Occupational Therapy

Prescriptions should be realistically related to activities of daily living (such as nutrition, elimination, dressing and locomotion), in light of the recipient's functional limitations. The specific goals of training or devices prescribed should be indicated.

Specific Prescription
Requirements for
Audiology Services

Prescriptions for audiologic services should include the following information regarding the recipient:

- Age
- Medical condition requiring evaluation or treatment
- Ability to perform the specific testing procedures prescribed
- Projected treatment depending upon the result of audiometric testing or evaluation

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**Prescription Requirements
for Orthotic and Prosthetic
(O & P) Appliances**

The written prescription of a licensed practitioner, acting within the scope of his or her practice, is a Medi-Cal program requirement for the provision of orthotic and prosthetic (O & P) appliances. When the cumulative program cost for purchase, rental or repair/maintenance of such appliances is \$250 for orthotics and \$500 for prosthetics, prior authorization is required (*California Code of Regulations* [CCR], Title 22, Section 51315[a][2]).

Medical Necessity

With the passage of AB1074 (1985), the Medi-Cal program 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 O & P appliances may only be covered as medically necessary to restore bodily functions essential to activities of daily living, or to prevent significant physical disability or serious deterioration of health, or to alleviate severe pain. The practitioner prescribing the items must supply the O & P dealer with information required to document the medical necessity for the item(s) according to the above criteria.

Prior Authorization

If a TAR is required, a copy of the prescription itself must accompany the TAR submitted to the Medi-Cal field office and contain all the data listed below.

Required Information

In addition to the signature of the practitioner, the following information must be supplied on the prescription form:

- Name, address and telephone number of the prescribing practitioner
- Date of prescription
- Item being prescribed
- California State license number

**Foot Inserts/
Arch Supports**

Foot insert and arch support codes L3000 – L3090 are reimbursable.

Note: Frequency is limited to one in five years.

Billing Limitations

Reimbursement for codes L3000 – L3030 is limited to ICD-9-CM diagnoses codes 045.1, 250.6, 250.7, 343, 355.6, 713.5, 714, 716.97, 718.57, 726.7 – 726.79, 728.71, 734, 735.8, 736.7 or 754.6. and may be subject to denial if billed for the same recipient in excess of expected reasonable and customary usage.

Reimbursement for premolded, removable foot arch supports (not custom-made) (HCPCS codes L3040 – L3060) is limited to two in six months. Reimbursement for non-removable, foot arch supports that are attached to the shoe (HCPCS codes L3070 – L3090) is limited to six in 12 months.

Medical Justification

If premolded, removable arch supports (codes L3040 – L3060) have been previously reimbursed, additional custom-made foot inserts (L3000 – L3030), billed within 30 days, require justification on or attached to the claim. Similarly, if the custom-made inserts have been previously reimbursed within a six-month period, subsequent claims for premolded arch supports require justification.

Acceptable justification for additional foot arch supports includes documentation of circumstances such as: significant change in foot size or condition (due to growth, injury or surgery); loss; and wear or damage (to the extent that the support is not usable).

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Supplemental Information

Indicate the number of items needed, especially those that require laundering. Supplementary information should be given to justify the prescription of any custom-made or above-standard items, such as:

- Medical diagnosis(es)
- Explanation of need and the purpose for the appliance
- Duration of medical necessity (Specific length of time should be indicated, including permanent or lifetime should the diagnosis support such use. For short-term use, the specific number of weeks or months should be stated.)
- Relevant history and physical documenting prior functional level and future anticipated functional level
- Date and type of surgery or injury if applicable
- Identity item requested with associated HCPCS code

For repair, maintenance or replacement, include clinical documentation with reference to age of the appliance, physical condition of the appliance and the anticipated functional level of the patient.

A specific length of time should be indicated, including “permanent” or “lifetime,” when the diagnosis supports such use. For short-term use, the specific number of weeks or months should be stated.

Note: A copy of the written prescription should not be attached to the claim when it is submitted for payment, but must be kept in the provider’s files.

Elastic Stockings

Custom-made elastic gradient compression stockings or sleeves (HCPCS code A6549) are reimbursable, with authorization, when medically necessary to treat symptomatic venous insufficiency or lymphedema in the lower extremities.

Providers billing for custom elastic stockings must have a written prescription from a licensed practitioner for the item(s). A generic prescription for “elastic support stockings” is not acceptable. The prescription must specify the compression measurement and length of the stocking.

Prescription Requirements for DME Rentals and Purchases

The written prescription of a licensed practitioner, acting within the scope of his or her practice, is a requirement of the Medi-Cal program for all Durable Medical Equipment (DME) rentals and purchases.

Required Information

In addition to the signature of the practitioner, the following specific information must be supplied clearly on the prescription form:

- Full name, address and telephone number of the prescribing practitioner, if not preprinted on the prescription form
- Date of prescription
- Item(s) being prescribed (If multiple or above-standard items are prescribed, these facts must be separately specified.)
- Medical condition necessitating the particular DME item (A supplemental summary of the medical condition or functional limitations may be attached to the prescription.)
- Duration of medical necessity (The term of use should be stated as precisely as possible; for example, short-term use in months and long-term use as “permanent,” “indefinite” or “lifetime.”)

Note: A copy of the written prescription should not be attached to the claim when it is submitted for payment, but must be kept in the provider’s file.

Blood Glucose Monitors

Blood glucose monitors (glucometers), with or without special features, may be prescribed for the purpose of monitoring a recipient's blood glucose levels at home when the recipient has any of the following conditions:

- Type I insulin-dependent diabetes
- Type II non-insulin-dependent diabetes
- Diabetes Mellitus complicating pregnancy
- Gestational diabetes

Home blood glucose monitors are billed with HCPCS code E0607. Blood glucose monitors with special features (for example, an integrated voice synthesizer or integrated lancing/blood sample) are billed with HCPCS codes E2100 and E2101. Reimbursement is limited to one glucometer every five years when billed for the same recipient, by any provider.

Documentation Requirements

Claims for any blood glucose monitor must include the ICD-9 diagnosis (including all relevant digits) related to the type of diabetes for which the instrument is being prescribed. Claims for code E0607 must contain documentation that the recipient or caregiver is competent to monitor the equipment and that the device is designed for home rather than clinical use.

Authorization

Authorization is always required for glucometers with special features (HCPCS codes E2100 and E2101). Authorization is required for code E0607 only when the cost exceeds the established *Treatment Authorization Request (TAR)* threshold limits for rental or purchase of DME.

The TAR must contain the following documentation:

- Diagnosis of Secondary diabetes mellitus (249.00 – 249.91, with a fifth digit of 0 or 1), Diabetes mellitus (250.0 – 250.9 with a fifth digit of 0 through 3), Diabetes Mellitus complicating pregnancy (648.0 thru 648.09), or gestational diabetes (648.8 – 648.89) with intent to monitor blood glucose at home, and
- Written statement that the requested glucometer is the least costly item available that will meet the recipient's medical needs, and
- For codes E2100 and E2101, written explanation of the severity of the impairment justifying a special feature for the effective use of the equipment, and
- For codes E2100 and E2101, written statement that the recipient requesting a glucometer with special features is capable of using the equipment in the home setting, and is not dependent upon a caregiver for blood glucose testing. If the recipient is dependent upon a caregiver, the caregiver's need for any requested special features must be justified

Supplies

Glucometer test strips, lancets and other monitoring supplies are billed using specific medical supply codes. For information about specific codes, refer to the *Medical Supplies List* sections in the appropriate Part 2 manual.