# 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)
*Incontinence Medical Supplies* (incont)
*List of Contracted Advanced Wound Care Dressings* (mc sup wound)
*List of Contracted Diabetic Test Strips and Lancets* (mc sup diabetic)
*List of Contracted Incontinence Absorbent Products* (incont list)
*List of Contracted Incontinence Creams and Washes* (incont cr list)
*List of Contracted Intermittent Urinary Catheters* (mc sup urinary)
*List of Contracted Ostomy Supplies* (mc sup ostomy)
*List of Contracted Tracheostomy Supplies* (mc sup tracheostomy)
*List of Contracted Waterproof Sheeting* (mc sup sheeting)
*List of Medical Supplies: Billing Codes, Units and Quantity Limits* (mc sup billing)
*Medical Supplies* (mc sup)
*Medical Supplies: Billing Examples* (mc sup ex)

### Other References

Medi-Cal website (*www.medi-cal.ca.gov*)
Medi-Cal bulletins
Medi-Cal Learning Portal: Online Tutorials

# Description

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

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

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

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

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

# HCPCS and UPN Coding Requirements

HCPCS Level II codes do not require the use of modifiers. Using modifiers can result in denials. However, claims for all 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* (mc sup) section of the Part 2 provider manual.

## List of Contracted Wound Care Advanced Dressings

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

| Billing Code (HCPC | Manufacturer | Product Description | Item Number (referenc | UPN Qualifier | UPN | MAC and MAPC per UC | UOM | Effective Date of Chang | Publication Date |
|---|---|---|---|---|---|---|---|---|---|
| A6207 | Coloplast | Physiotulle Contact Layer 4" x 8" Box/3 | 3912 | EN | 5708932538879 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Coloplast | Physiotulle Contact Layer 4" x 8" Case/300 | 3912 | EN | 5708932538886 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Coloplast | Physiotulle Contact Layer 4" x 8" Each | 3912 | EN | 5708932538862 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Coloplast | Physiotulle Contact Layer 6" x 6" Box/17 | 3920 | EN | 5708932538909 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Coloplast | Physiotulle Contact Layer 6" x 6" Case/170 | 3920 | EN | 5708932538916 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Coloplast | Physiotulle Contact Layer 6" x 6" Each | 3920 | EN | 5708932538893 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Coloplast | Physiotulle Contact Layer 6" x 8" Box/17 | 3915 | EN | 5708932538848 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Coloplast | Physiotulle Contact Layer 6" x 8" Case/170 | 3915 | EN | 5708932538855 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Coloplast | Physiotulle Contact Layer 6" x 8" Each | 3915 | EN | 5708932538831 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Crawford Hlthcare | KerraContact Ag 4" x 5" Box/10 | PN-09-0103 | EN | 5060077231924 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Crawford Hlthcare | KerraContact Ag 4" x 8" Box/10 | PN-09-0104 | EN | 5060077231948 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Crawford Hlthcare | KerraContact Ag 6" x 6" Box/10 | PN-09-0105 | EN | 5060077231962 | $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Hollister | Restore contact layer Flex 4" x 5" Each | 506488 | UP | 813303010306 | ~~$14.54~~ $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Hollister | Restore contact layer Flex 6" x 8" Each | 506489 | UP | 813303010313 | ~~$14.54~~ $11.82 | ea | 4/1/2017 | February 2017 |
| A6207 | Medline | Versatel contact layer 4" x 7" | MSC1747EP | UK | 10884389151006 | ~~$11.94~~ $11.82 | ea | 4/1/2017 | February 2017 |

**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* (mc sup) section of the provider manual indicates which HCPCS Level II codes have a price on the formulary file, under the MAPC (Maximum Allowable Product Cost) column in the spreadsheet.

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

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

## Non-Contracted Product Information in the Provider Manual

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

**Medical Supplies Billing Codes, Units and Quantity Limits**

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 and cervical caps
- Heparin and normal saline flush solutions
- Enteral nutritional formula

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

## Paper Claim Format

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

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

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

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

# UPN Placement of UPN Product Qualifiers

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

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

UPNs are up to 19 digits in length.

## UPN Qualifier and UPN Placement: CMS-1500 Claim Form

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

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

# UPN Placement of Unit of Measure Qualifiers

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

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

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

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

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

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

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

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

| | 24. A. DATE(S) OF SERVICE From | | | To | | | B. PLACE OF SERVICE | C. | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | MM | DD | YY | MM | DD | YY | | EMG | 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 | 15 | 17 | | | | 12 | | A4399 | | | 23 00 | 2 | | NPI |
| 2 ON30003175507 | | | | | | | | UN0000002000 | | | | | | |
| 04 | 15 | 17 | | | | 12 | | A4367 | | | 15 00 | 2 | | NPI |
| 3 UP762123001493 | | | | | | | | UN0000006000 | | | | | | |
| 04 | 15 | 17 | | | | 12 | | A4363 | | | 14 00 | 6 | | NPI |
| 4 EN0762123010327 | | | | | | | | UN0000030000 | | | | | | |
| 04 | 15 | 17 | | | | 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 | 29. AMOUNT PAID |
|---|---|---|---|---|
| | | | $ 147 00 | $ |

| 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.) | 32. SERVICE FACILITY LOCATION INFORMATION | 33. BILLING PROVIDER INFO & PH # ( ) |
|---|---|---|
| SIGNED *Jane Doe* DATE 04/15/17 | a. NPI b. | JANE SMITH<br>1027 MAIN STREET<br>ANYTOWN, CA 958235555<br>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 percent above cost or usual and customary charge) for incontinence and medical supplies:

Medi-Cal will pay the lesser of the:

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

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

# Billing Tips

## Billing Tips for Service Code Groupings (SCGs)

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

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

## Billing Tips for TARs and SARs

- Refer to the provider manual for HCPCS Level II codes.
- Providers with a *Treatment Authorization Request* (TAR)/Service Authorization Request (SAR) for products approved under the wrong procedure code will be denied with RAD code 0225: "This is an incorrect procedure code and/or modifier for this service. Please resubmit."
- Product descriptions on the TAR/SAR must match the item description found on the catalog page, price list or invoice attached to the claim for reimbursement.
- See Guidelines B and C at the end of this module for additional tips from the TAR field office for TAR approval.
- Quantity unit requests on TARs must be billed in accordance to TAR guidelines for the type of TAR (medical or pharmacy) approved:
  - 180 total approved medical TAR units would equal 6 months times 30 units each month (6 x 30 = 180).
  - The provider would bill 30 units or less each month and the TAR would be reduced accordingly by 30 units or less each billing until the total units were depleted.
  - Six (6) total approved pharmacy TAR units would equal 30 per month for a period of 6 months. The TAR would be reduced by 1 each month until the total units are depleted.
  - Since Medical and Pharmacy TARs employ different unit quantities, providers must be sure to bill for the correct units based on the type of TAR (medical or pharmacy) being submitted.
  - When billing for incontinence products without a TAR or SAR, the quantity billed must not exceed the quantity limits listed in the "Incontinence Medical Supplies Billing Codes" table in the *Incontinence Medical Supplies* (incont) section of the Part 2 provider manual. When billing for incontinence medical supplies that require an approved TAR or SAR, the quantity billed must not exceed a one-month supply (the total quantity approved divided by the number of months approved) in a 27-day period. This billing requirement also applies to claims with a TAR or SAR to exceed the $165 per-month limit for incontinence products.

## Additional Billing Tips

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

- A4212 – Huber needles
- A4215 – Pen needles
- A4223 – I.V. sets, connecting device, heparin lock caps. Does not include I.V. prep wipes, transparent dressings, I.V. start kits, etc. Refer to the provider manual for correct billing codes.
- A4322 – Irrigation syringe, regardless of how used (for example, used for feeding or irrigation 50 ml and over, common size 60 ml) when billing attachment does not describe the item otherwise.
- A4628 – Yankauers
- A9274 – Omni Pods
- B9999 – Empty I.V. bags, I.V. catheters, PICC supplies
- J1731 – Hypertonic saline solution, 1 ml (TAR required). Submit TARs to the TAR Processing Center.
- T5999 – Decompression tubes, Peristeen Anal Irrigation

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

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

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

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

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

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

# Guidelines A: TARs for Incontinence and Medical Supplies

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

## Catalog/Price List Reimbursement

- Catalogs/price lists cannot be dated more than five (5) years before or after 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 percent mark-up.

### Incontinence Supplies *

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

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

## Billing Using HCPCS Level II Procedure Codes: No UPN Required

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

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

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

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

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

| 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 |

* As of July 1, 2017, the HCPCS code will no longer be reimbursable as a Medi-Cal benefit.

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

- For beneficiaries in an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) or Intermediate Care Facility for the Developmentally Disabled/Nursing (ICF/DD-N), mattress covers and gloves are not to be included on a TAR for incontinence supplies. These are medical supply items.
- A TAR, along with specific medical justification and documentation, is needed to support products that meet the description of a non-contracted incontinence HCPCS code for amounts that exceed the utilization limits. For example, toilet training progress reports, bladder/bowel assessments, incontinent flow records or client care flow records. The medical diagnosis must be related to bowel/bladder incontinence.
- TARs for patients in ICF/DD-H or ICF/DD-N homes are usually authorized for one year or up to the expiration date on the prescription.
- TARs for pediatric-sized diapers over the quantity limit are approved for six (6) months if the child is close to 40 pounds. Children 40 pounds and over must use diapers on the contract list. Non-contracted products may be used for children weighing less than 40 pounds.
- Protective underwear/pull-ons are included on the contracted list for patients over 80 pounds. Direct-bill this item for patients living at home or in board and care. TARs are required when the utilization limit is exceeded, along with medical justification, to be eligible for the $165 per-month allowance.
- TARs may be approved for over-utilization limits with medical justification or documentation to support. For example: "Patient is bedbound, taking medication resulting in increased urine output, chronic diarrhea, G-tube feeds."
- Prescription is only good for a period of 1 year from when it is signed and dated by the physician or when there is an authorization period indicated.
- Residents in an ICF/DD-H or ICF/DD-N are exempt from the optional benefits exclusion criteria. The provider can submit a TAR and request the full unit amount. Approval for the full unit amount will be based on medical necessity. The provider cannot bill direct for patients residing in an ICF/DD-H or ICF/DD-N.
- Medi-Cal does not reimburse for incontinence supplies for recipients younger than 5 years of age. Medi-Cal may reimburse for incontinence supplies through the Early and Periodic Screening, 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:<br>Washes: 960 ml per bottle<br>Creams: 540 grams, weight may vary<br>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.<br>For one (1) tube of cream at 540 grams: 540 grams x 12 months = 6,480 grams, or units.

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

## Gloves

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

## Wipes

This is a covered benefit only with medical justification.

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

## New Prescriptions

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

## Medicare Coverage for Medical Supplies

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

## Medicare EOB Denials and OHC Denials

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

## Submission and Reimbursement: Miscellaneous

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

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

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

## Nipple feeders

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

## Self-Reinflating Resuscitator bags

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

## Blood pressure apparatus

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

## Nebulizer machines

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

## HCPCS code A4930

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

## Non-sterile disposable gloves

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

## Gauzes

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

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

## Tape

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

## Prescriptions

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

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

## Reauthorization requests

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

## Duplicate TAR requests

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

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

## TARs: Miscellaneous

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

# Guidelines D: 90-Day Frequency Limitations for Medical Supplies

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

## Scenario 1

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

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

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

## Scenario 2

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

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

## Scenario 3

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

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

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

# Medical Supplies Common Denials

| RAD Code | Reason RAD Description | Billing Tips |
|---|---|---|
| 0005 | The service billed requires an approved TAR *(Treatment Authorization Request).* | 1. Procedure code requires a TAR.<br>2. The quantity and frequency limits have been exceeded.<br>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. |
| 9556 | Either the invoice or the certification is missing or invalid. | Verify the certification statement is written exactly as shown in the provider manual. Line number or product number required. Each item billed requires a separate certification statement. |
| 9670 | Claim date of service does not match date of service on SAR (Service Authorization Request) file. | Verify span date on SAR authorization with DOS (Date of Service). |
| 9671 | Procedure code has not been authorized by CCS/GHPP (California Children's Services/Genetically Handicapped Persons Program). | Verify procedure code being billed is listed on authorization. |
| 9713 | The date on the catalog or invoice is missing or invalid. | Date on catalog cannot be older than five (5) years prior to the date of service on the claim. Invoice date cannot be more than one (1) year prior to date of service. |
| 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. |