Pharmacy Billing: Home Infusion, Compound Drugs, Durable Medical Equipment & 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

Acronyms

A list of current acronyms is located in the Appendix section of the complete workbook.
Program Coverage

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

The Medi-Cal program covers legend drugs listed on the CDL of the Pharmacy Part 2 provider manual. Legend drugs not listed may be payable subject to authorization from a Medi-Cal field office consultant.

Non-legend drugs or over-the-counter (OTC) products also 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. Please review the Reimbursement (reimbursement) and Pharmacy Claim Form (30-1): Special Billing Instructions (pcf30-1 spec) sections of the Part 2 provider manual for more information. Pharmacy providers offering discounts to the general public must be available on the same terms and conditions to Medi-Cal customers. Failure to do so may result in billing the Medi-Cal program more than the usual and customary amount charged to the general public for the same service and is prohibited by California Code of Regulations (CCR), Title 22, Sections 51480 and 51513 (b)(1)(A), (c) and in accordance with Title 42, Code of Federal Regulations, Part 447.331.
Claims Billing Methods

Electronic Claims

- Online 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
    - Contact 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 not 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
  - 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 on the claim form:

  ![Claim Form Diagram]

- If attachments are required, ensure that staples go in the appropriate “Fasten Here” area of the claim form
  - 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 23 ingredients (due to the newly-updated 30-4 form), 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:

![Login screen for RTIP](image1)

2. On the “Claims” tab, select “RTIP”:

![Claims tab](image2)
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. You must enter the requested information in the field for your claim to process successfully.

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 and Service Provider ID: The "Provider ID Qualifier" is pre-populated with "01" to identify the NPI number to follow in the "Service Provider ID" field. Only a 10-digit NPI will be accepted. Do not submit claims using a Medicare provider number or state license number.

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.

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.
   - Examples of codes:
     01 = Pharmacy
     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. **Gender and Birth Date**: Patient’s gender of female or male. Patient’s Birth Date in MMDDCCYY format, where MM is the two-digit month, DD is the two-digit day, CC is the two-digit century and YY is the two-digit year. An example of a birth date would be 03081945.

k. **Prescriber ID Qualifier and Prescriber ID**: The “Prescriber ID Qualifier” is pre-populated with “01” to identify the NPI number to follow in the “Prescriber ID” field. Enter the prescriber’s 10-digit NPI. Do not use the DEA registration number.

l. **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.

m. **Fill Number**. A refill number (0 or 00 for original dispensing, 1 or 01 for the first refill to 99 for the 99th refill) is required in this field.

n. **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.

o. **Days Supply**: Enter the estimated number of days supply for the drug dispensed.

p. **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. Providers are also reminded that the charge is for the total amount dispensed. For example, if the quantity dispensed is seven bags containing 110mL per bag, the quantity dispensed should be 770mL, and the charge should be for 770mL.

q. **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 applicable. For more information, see the Share of Cost (SOC): 30-1 for Pharmacy section (share ph) of the Part 2 provider manual.
r. **Other Coverage Code:** Select the appropriate code from the drop-down menu to indicate whether the patient has other insurance coverage, and if so, the extent and status of the coverage for the claim being submitted.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No other coverage identified</td>
</tr>
<tr>
<td>2</td>
<td>Other coverage exists-payment collected</td>
</tr>
<tr>
<td>3</td>
<td>Other coverage exists-this claim not covered</td>
</tr>
<tr>
<td>4</td>
<td>Other coverage exists-payment not collected</td>
</tr>
</tbody>
</table>

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

t. **ICD-CM Type, Primary ICD-CM and Secondary ICD-CM:** 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.
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 the appropriate options from the drop-down menu.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Specified</td>
</tr>
<tr>
<td>7</td>
<td>Medically Necessary (Code 1 met)</td>
</tr>
<tr>
<td>8</td>
<td>Process Compound for Approved Ingredients (Code 1 met and Process for Approved Ingredients)</td>
</tr>
<tr>
<td>99</td>
<td>Other (Code 1 met and Process for Approved Ingredients)</td>
</tr>
</tbody>
</table>

Select “7” (Medically Necessary) if the drug(s) is/are subject to Code 1 restrictions and these restrictions have been met per the CDL requirement(s).

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 covered per the CDL will be paid accordingly, while ingredients not covered will not be paid.

Select 99 (Other) if Code 1 is met AND you would like the submission to be processed for approved ingredients only.

Select 0 (Not Specified) if the other three options are not applicable.

b. **Incentive Amount**: Enter the sterility test fee, if sterility testing was performed. Include the decimal point (.) when indicating cents.

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.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prior Authorization (TAR)</td>
</tr>
<tr>
<td>8</td>
<td>Payer Defined Exemption (Discharge Date)</td>
</tr>
</tbody>
</table>

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
- 02: Dental
- 03: Inhalation
- 04: Injection
- 05: Intraperitoneal
- 06: Irrigation
- 07: Mouth/Throat
- 08: Mucous Membrane
- 09: Nasal
- 10: Ophthalmic
- 11: Oral
- 12: Other/Miscellaneous
- 13: Otic
- 14: Perfusion
- 15: Rectal
- 16: Sublingual
- 17: Topical
- 18: Transdermal
- 19: Translingual
- 20: Urethral
- 21: Vaginal
- 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
- 02: Ointment
- 03: Cream
- 04: Suppository
- 05: Powder
- 06: Emulsion
- 07: Liquid
- 10: Tablet
- 11: Solution
- 12: Suspension
- 13: Lotion
- 14: Shampoo
- 15: Elixir
- 16: Syrup
- 17: Lozenge
- 18: Enema

- **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."
6. Hit the "Submit" button 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):

![Pharmacy Claim Reversal Option](image1)

b. Select “Recall Data from last Transaction”, if the prescription to reverse is the last one that was billed.

![Recall Data from last Transaction](image2)

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. This is to reverse any billed claim.
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:

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 14: Indicate “Y” (yes) if the Code 1 restriction for the compound drug has been met. If one or more of the ingredients have a code 1 restriction, all code 1 restrictions must be met to indicate “Y”. If none of the ingredients have a code 1 restriction, the field can be left blank.

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, use box 17 to indicate patient location.
- 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 21: 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 22: 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.

- 30-4 paper claims do not require decimals to differentiate between dollars and cents.

There is a separation pre-printed on the form to distinguish the difference. Do not enter a dollar ($) sign on a paper claim.
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:

<table>
<thead>
<tr>
<th>Ingredient Product ID Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>99</td>
</tr>
</tbody>
</table>

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 40: 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 42: 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 43: Enter the number of container counts.
Signature of Provider and Date
- RTIP: No signature or date is required
- 30-4 paper claim, box 47: 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 “9999999999” for the container count. If the compound contains more than 25 product codes, then a 30-4 paper claim must be submitted.
- 30-4 paper claim: Claim form has only 23 lines, therefore, any additional ingredients will be required to be billed on an attachment.
  - The 23rd 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:

```
  99  999999999998
      WHOLE UNITS: 660  QTY: 3405.71
```

<table>
<thead>
<tr>
<th>Product Code</th>
<th>Description</th>
<th>Unit</th>
<th>Quantity</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>Product 99</td>
<td>UN</td>
<td>660</td>
<td></td>
</tr>
</tbody>
</table>

Specific Details/Remarks: 
- 10 ingredients
- Container Count: 10
- Other:
The Compounded Drug Attachment should contain the pharmacy name, provider ID, prescription number and date of service:

<table>
<thead>
<tr>
<th>Pharmacy Name:</th>
<th>ABC Home Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Number:</td>
<td>0123456789</td>
</tr>
<tr>
<td>Prescription Number:</td>
<td>1234567</td>
</tr>
<tr>
<td>Date of Service:</td>
<td>03/02/2007</td>
</tr>
</tbody>
</table>

### Additional Compound Ingredients:

<table>
<thead>
<tr>
<th>NDC/UPC/HRI #</th>
<th>Quantity</th>
<th>Charge</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61703022521</td>
<td>360.00</td>
<td>3386.70</td>
<td></td>
</tr>
<tr>
<td>00517240025</td>
<td>300.00</td>
<td>18.41</td>
<td></td>
</tr>
</tbody>
</table>

**Totals**

- It must also contain the additional compound ingredients (NDCs) and total quantity and charge.
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:**

<table>
<thead>
<tr>
<th>Item Being Billed</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of ingredients</td>
<td>Paid at Actual Acquisition Cost (AAC)</td>
</tr>
<tr>
<td>Cost of supplies consumed in compounding I.V. solution</td>
<td>Paid at Maximum Allowable Product Cost (MAPC*), by report or price on file, up to $5.56 per container</td>
</tr>
<tr>
<td>Cost of empty containers <em>NOTE</em></td>
<td>Paid at Maximum Allowable Product Cost (MAPC*), by report.</td>
</tr>
<tr>
<td>Empty containers must be billed separately from the compound claim.</td>
<td></td>
</tr>
<tr>
<td>Cost of sterility testing (only when performed)</td>
<td>Up to $0.32 per container</td>
</tr>
<tr>
<td>Professional Dispensing fee <em>NOTE</em></td>
<td>Less than 90,000 claims per year equals $13.20 (requires annual provider self-attestation)</td>
</tr>
<tr>
<td>Refer to the Reimbursement section of the Part 2 provider manual for further information.</td>
<td></td>
</tr>
<tr>
<td>90,000 or more claims per year equals $10.05.</td>
<td></td>
</tr>
<tr>
<td>Compounding fee <em>NOTE</em></td>
<td>$0.99 per container (in addition to professional fee, for compounded solutions only)</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>*Maximum Allowable Product Cost as defined by Welfare &amp; Institutions Code 14105.47.</td>
<td></td>
</tr>
<tr>
<td>Capsules, powders, tablets, lozenges:</td>
<td>$1.98</td>
</tr>
<tr>
<td>6-36...................................................................$1.98</td>
<td></td>
</tr>
<tr>
<td>37 and over...................................................$3.95</td>
<td></td>
</tr>
<tr>
<td>Ointments and creams:</td>
<td>$1.64</td>
</tr>
<tr>
<td>1 gm to 179 gm..............................................$1.64</td>
<td></td>
</tr>
<tr>
<td>180 gm and over..............................................$3.29</td>
<td></td>
</tr>
<tr>
<td>Suppositories:</td>
<td>$3.29</td>
</tr>
<tr>
<td>1 to 23 .................................................................$3.29</td>
<td></td>
</tr>
<tr>
<td>24 and over...................................................$5.76</td>
<td></td>
</tr>
<tr>
<td>Sterile eye preparations:</td>
<td>$2.04</td>
</tr>
<tr>
<td>All ....................................................................$2.04</td>
<td></td>
</tr>
<tr>
<td>Nose and ear preparations:</td>
<td>$0.81</td>
</tr>
<tr>
<td>All ....................................................................$0.81</td>
<td></td>
</tr>
<tr>
<td>Emulsions, lotions:</td>
<td>$0.81</td>
</tr>
<tr>
<td>1 cc to 239 cc..............................................$0.81</td>
<td></td>
</tr>
<tr>
<td>240 cc and over..............................................$1.64</td>
<td></td>
</tr>
<tr>
<td>Liquids other than simple pouring or reconstituting solutions, shampoos, elixirs, syrups, suspensions, enemas:</td>
<td>$0.99</td>
</tr>
</tbody>
</table>
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 TSC agent cannot sufficiently assist you, please notify the TSC agent that you are requesting to be contacted by your Provider Field Representative for assistance and/or request an onsite visit.

<table>
<thead>
<tr>
<th>TSC Main Menu Prompt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telephone Service Center (TSC): 1-800-541-5555</strong></td>
</tr>
</tbody>
</table>

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**: Every Woman Counts Inquiry System 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 billing inquiries
- **Press or say 7**: If you are assisting a hearing impaired caller

<table>
<thead>
<tr>
<th>Secondary Menu Prompt Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option 4</strong></td>
</tr>
<tr>
<td><strong>Press or say 1</strong>: For Every Woman Counts Inquiry System</td>
</tr>
<tr>
<td><strong>Press or say 2</strong>: For CMC, PCIS/Internet, eTAR, LSRS, Pharmacy/CALPOS, CHDP Gateway, HIPAA, Hospital Presumptive Eligibility (HPE) or Presumptive Eligibility for Pregnant Women</td>
</tr>
<tr>
<td><strong>Press or say 3</strong>: For dates and locations of Medi-Cal provider training seminars</td>
</tr>
</tbody>
</table>

| **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 |

| **Option 6** |
| **Press or say 1**: For Provider Enrollment |
| **Press or say 2**: For TAR |
| **Press or say 3**: For Every Woman Counts billing inquiries, EWC |
Resource Information

References

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)*

*Share of Cost (SOC): 30-1 for Pharmacy (share ph)*

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
Durable Medical Equipment

Introduction

Purpose

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

Module Objectives

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

Acronyms

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

Medi-Cal covers DME when provided on a written prescription (or electronic equivalent) of a licensed physician. A recipient’s need for DME items must be reviewed annually by a physician.

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

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

Nursing Facility Coverage

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

DME Policies and Clarifications

2019 Policies

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

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

Face-to-Face Encounter
A face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist or physician assistant is required for all DME items. Face-to-face encounters may be done via telehealth. For all DME items that require replacement or replacement parts, a new prescription written by the physician for the DME item is required annually.

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

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

- Positioning of body is not feasible in non-hospital beds.
- Recipient needs promotion of body alignment to prevent contractures and has a history of contractures or a documented medical condition that causes risk of contractures.
- Recipient needs alleviation of pain with a documented history of such pain related to positioning.
- Recipient needs avoidance of respiratory infections with a documented history of respiratory infection related to positioning.
- Recipient needs elevation of the head of the bed more than 30 degrees due to certain medical conditions such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or documented history of aspiration.
- Recipient needs use of special attachments or traction equipment.
Portable Ramps
A fixed, modular or in any way attached ramp is considered a non-portable ramp and is not a Medi-Cal benefit. Portable ramps are those that are foldable or collapsible, not attached, suitcase types, which can be easily and readily carried and transported by the recipient for use in multiple locations. The portable ramp usually weighs no more than 90 pounds or measures no more than 10 feet in length.

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

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

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

NOTES
Product Classification

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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Website Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Medical Review Policies</td>
<td>(<a href="http://www.noridianmedicare.com">www.noridianmedicare.com</a>)</td>
</tr>
<tr>
<td></td>
<td>(<a href="http://www.dmepac.com">www.dmepac.com</a>)</td>
</tr>
</tbody>
</table>

Code Frequency Limits

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

Warranties

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

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

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

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

CCS-Only Benefits

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0482</td>
<td>Cough stimulating device, alternating positive and negative airway pressure</td>
</tr>
<tr>
<td>E0635</td>
<td>Patient lift, electric, with seat or sling</td>
</tr>
<tr>
<td>E0639</td>
<td>Patient lift, movable from room to room with disassembly and reassembly,</td>
</tr>
<tr>
<td></td>
<td>includes all components/accessories</td>
</tr>
</tbody>
</table>

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

DME Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NU</td>
<td>New equipment</td>
</tr>
<tr>
<td>RR</td>
<td>Rental</td>
</tr>
<tr>
<td>RB</td>
<td>Replacement as part of repair</td>
</tr>
<tr>
<td>KC</td>
<td>Replacement of special power wheelchair interface</td>
</tr>
<tr>
<td>QA</td>
<td>Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts is less than one LPM</td>
</tr>
<tr>
<td>QB</td>
<td>Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds four LPM</td>
</tr>
<tr>
<td>QE</td>
<td>Prescribed amount of oxygen is less than one liter per minute (LPM)</td>
</tr>
<tr>
<td>QF</td>
<td>Prescribed amount of oxygen exceeds four LPM and portable oxygen is prescribed</td>
</tr>
<tr>
<td>QG</td>
<td>Prescribed amount of oxygen is greater than four LPM</td>
</tr>
<tr>
<td>QR</td>
<td>Prescribed amounts of stationary oxygen for daytime use while at rest and nighttime use differ and the average of the two amounts exceeds four LPM</td>
</tr>
<tr>
<td>SC</td>
<td>Medically necessary service or supply (used for second unit of oxygen content)</td>
</tr>
<tr>
<td>LT</td>
<td>Left Side</td>
</tr>
<tr>
<td>RT</td>
<td>Right Side</td>
</tr>
</tbody>
</table>

Tax

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

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

Authorization Requirements

Authorization is required under the following circumstances:

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

Prescriptions

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

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

Certificates of Medical Necessity

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

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

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

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

Documentation Requirements

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

- The mobility and seating impairment to be accommodated
- Equipment currently owned by the recipient, detailed features of the DME item and the date of purchase
- Verification and documentation that other treatments of lesser mobility devices do not safely accommodate the recipient’s mobility impairment
- Verification and documentation that the requested equipment fits and is usable in all living areas used by recipient
- An explanation describing how the living areas will be accessed by the recipient with the requested equipment
- Verification and documentation that the recipient and/or caregiver understands how to care for and use the requested equipment
- Seating evaluation by a qualified therapist/Assistive Technology Professional (ATP) for the following:
  - Neurological conditions
  - Complex orthopedic along with neurological conditions
  - Pediatric wheelchairs

Refer to the Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories section (dura bil wheel) and Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines section (dura wheel guide) in the appropriate Part 2 provider manual for information.
Bundle all accessories with the basic piece of equipment under the main code. For example:

- Gait trainers: Codes E8000 – E8002
- Bath bench: Code E0240
- Standing frames: Codes E0630, E0641 and E0642
- Position seat: Code T5001

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

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

NOTES
Equipment

Oxygen/Respiratory Therapy

Revised Criteria Expansion for Oxygen and Respiratory Equipment
Effective July 1, 2017, the criteria for DME oxygen contents and oxygen equipment and respiratory equipment has been revised to align Medi-Cal policy with Medicare policy. The revision includes requirements for blood gas studies and other clinical criteria that must be met to qualify for supplemental oxygen. Portable oxygen systems have also been revised. For more information, refer to the Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment section (dura bil oxy) in the Part 2 provider manual.

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

A TAR/SAR is required for all respiratory DME except for the following:
- A7005 (administration set, with small volume nonfiltered pneumatic nebulizer, nondisposable) – billing limit of one in six months
- E0484 (oscillatory positive expiratory pressure device, non-electric, any type, each) – billing limit of two in 12 months

Portable Oxygen

Code E0443: Oxygen Contents (Gas)
Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), a one-month supply = one unit.

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

NOTE
One unit is defined as “250 cubic feet” for the first supply of contents and any amount for the second supply of contents (second unit).
- Modifier NU must be used when billing code E0443 for the first unit and modifier SC must be used for the second unit. A maximum of two units is allowed per month.

For example: E0443NU quantity of 1
E0443SC quantity of 1
**Code E0444: Oxygen Contents (Liquid)**

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

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

**NOTE**

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

For example:
- E0444NU quantity of 1
- E0444SC quantity of 1

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

**Oxygen Specific Modifiers**

**Rented Equipment**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Oxygen Flow Rate</th>
<th>Reimbursement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>RR</td>
<td>1 – 4 LPM</td>
<td>$144.74</td>
</tr>
<tr>
<td>QE or QA</td>
<td>&lt; 1 LPM</td>
<td>$72.37 (reduced by 50 percent)</td>
</tr>
<tr>
<td>QF or QB</td>
<td>&gt; 4 LPM Portable oxygen is prescribed</td>
<td>$217.11 (increased by 50 percent)</td>
</tr>
<tr>
<td>QG or QR</td>
<td>&gt; 4 LPM Portable oxygen is not prescribed</td>
<td>$217.11 (increased by 50 percent)</td>
</tr>
</tbody>
</table>

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

For example:
- E1390RR
- E1390QG

**NOTES**
Wheelchairs

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

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

  For example: Box 19 – Tom Smith, RESNA

Reimbursement Conditions
Reimbursement will be the lesser of:

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

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

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

Claim Requirements for Unlisted DME Non-Wheelchairs

Reimbursement Conditions
Reimbursement will be the lesser of:

- 80 percent of MSRP catalog dated on or prior to the date of service, or
- Manufacturer’s invoice plus 67 percent markup, or
- The billed amount
Claim Requirements for Unlisted DME Supply HCPCS “A” Codes
Claims must include the following information to receive reimbursement:

- In the Additional Claim Information field (Box 19), a statement that the equipment is “patient owned” and either the description of the equipment or the procedure code of the owned equipment must be included.
  
  **For example:** Patient-owned nebulizer with compressor E0570

Reimbursement Conditions
Reimbursement will be the lesser of:

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

“By Report” Attachment Exceptions
- For custom-made equipment with no MSRP available, submit the manufacturer’s purchase invoice. If the invoice does not indicate that the item is “custom,” handwrite a statement on the invoice “custom and no MSRP available.”
- If there is no MSRP available for the item billed, submit the manufacturer’s invoice and explain the lack of MSRP.
- If the provider is renting the piece of equipment from another provider or manufacturer, and unable to purchase, submit the rental invoice showing the rental cost and the appropriate MSRP catalog page.
- When the provider and the manufacturer are the same, attach the MSRP or catalog page with the appropriate date.

Approved attachments for DME claims
- MSRP catalog page dated on or prior to the date of service
- Manufacturer’s invoice dated prior to the date of service
- Manufacturer quotes if MSRP is not available along with a manufacturer purchase invoice
- Manufacturer’s invoice dated prior to date of service, with MSRP on the same page

Equipment Repair/Maintenance
- Medi-Cal only repairs equipment owned by the Medi-Cal patient
- Labor codes:
  - K0739: all equipment except oxygen/respiratory equipment
  - K0740: oxygen/respiratory equipment
- Do not use a modifier with the labor code
- Bill the labor time needed to accomplish the work in 15-minute units. The labor time may be rounded to the nearest half-hour for the total repair job.
  
  **For example:** 1 hour and 20 minutes = 6 units
- Hourly labor payment rate for DME repair is $65.88 (one 15-minute “unit” is $16.47)
Patient-Owned Equipment

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

- In the Additional Claim Information field (Box 19) provide a description of the equipment and that the equipment is patient-owned.
  For example: Box 19: Repair of patient-owned manual wheelchair K0005 (ultralightweight wheelchair).
- Use modifiers RB and NU for replacement of wheelchair parts.
  For example: E2211RBNU Pneumatic tires K0739 Labor

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

- Box 19: Statement that the equipment is owned by the patient, e.g. “Repair of patient-owned patient lift E0630”
- Description of service provided
- Reason/justification for repair
- Manufacturer’s name
- Do not bill for more than the quantity of (1) when repairing a non-wheelchair piece of equipment. The claim will be denied for exceeding the NCCI edit. Bill with (1) unit and include all the pieces of the parts you replaced on the attachment.
- List of parts used, including catalog numbers and cost for “By Report” items
  For example: E0630RB Patient Lift K0739 Labor

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

- Box 19: Statement that the respiratory equipment is owned by the patient, e.g. “Repair of patient-owned continuous positive airway pressure (CPAP) – E0601”
- Description of service provided
- Reason/justification of repair
- Manufacturer’s name
- List of parts used, including catalog numbers and cost for “By Report” items
  For example: E0601RB CPAP K0740 Labor
# DME Common Denials

## Remittance Advice Details

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

**NOTES**

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Resource Information

References

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

Part 2
- Durable Medical Equipment (DME): An Overview
- Durable Medical Equipment (DME): Bill for DME
- Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment
- Durable Medical Equipment (DME): Bill for Wheelchairs and Wheelchair Accessories
- Durable Medical Equipment (DME): Billing Codes: Frequency Limits
- Durable Medical Equipment (DME): Billing Examples
- Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines

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

Introduction

Purpose

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

Module Objectives

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

Acronyms

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

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

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

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

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

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

HCPCS and UPN Coding Requirements

HCPCS Level II codes do not require the use of modifiers. Using modifiers can result in denials. However, claims for all 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 strikethrough. MAC refers to the maximum acquisition cost guaranteed by the manufacturer, upon request, for dispensing to eligible Medi-Cal fee-for-service recipients. MAC refers to the maximum allowable product cost reimbursed. UOM refers to the unit of measure.

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Manufacturer</th>
<th>Product Description</th>
<th>Item Number (reference)</th>
<th>UPN Qualifier</th>
<th>MAC</th>
<th>Effective Date of Change</th>
<th>Publication Date</th>
</tr>
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<tbody>
<tr>
<td>E6207</td>
<td>Coloplast</td>
<td>Physiogel Contact Layer 4” x 8” Box/3</td>
<td>3012</td>
<td>EN</td>
<td>5789025388870</td>
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<td>EN</td>
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<td>$11.82</td>
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<td>Physiogel Contact Layer 5” x 8” Box/17</td>
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<td>5789025389116</td>
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<td>3020</td>
<td>EN</td>
<td>5789025388893</td>
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<td>ea</td>
</tr>
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<td>ea</td>
</tr>
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<td>ea</td>
</tr>
<tr>
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<td>Coloplast</td>
<td>Physiogel Contact Layer 6” x 8” Box/17</td>
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<td>5789025388831</td>
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<td>ea</td>
</tr>
<tr>
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<td>5060077219924</td>
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<td>ea</td>
</tr>
<tr>
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</tr>
<tr>
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<tr>
<td>E6207</td>
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<td>UP</td>
<td>513305010368</td>
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<td>ea</td>
</tr>
<tr>
<td>E6207</td>
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<td>Restore contact layer Flex 6” x 8” Each</td>
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<td>UP</td>
<td>513305010513</td>
<td>$11.82</td>
<td>ea</td>
</tr>
<tr>
<td>E6207</td>
<td>Medline</td>
<td>Versatone contact layer 4” x 7”</td>
<td>MSL1747EP</td>
<td>UK</td>
<td>10884392151006</td>
<td>$11.82</td>
<td>ea</td>
</tr>
</tbody>
</table>

### 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 bulletin. Updates or additions to the List will be bolded. Deletions will have strikethroughs. "MAPC" refers to the maximum allowable product cost reimbursed.

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

| Billing Code (HCPCS) | Restricted to Contracted Products (Y/N) | Description                                                                 | MAPC per Unit of Measure (UOM) | TAR Required (Y/N) | Quantity Limits Without Authorization | Billing Notes | Effective Date of Change | Publication Date |
|----------------------|----------------------------------------|-----------------------------------------------------------------------------|--------------------------------|--------------------|---------------------------------------|---------------|-------------------------|----------------|------------------|
| A4265                | N                                      | Syringe with needle, sterile, 1 ml or less                                   | By Report ea                   | N                  | 260 per 27-day period                  |               | Prior to 2/16/2015       | February 2015   |
| A4267                | N                                      | Syringe with needle, sterile 2 ml                                           | By Report ea                   | N                  | 260 per 27-day period                  |               | Prior to 2/16/2015       | February 2015   |
| A4268                | N                                      | Syringe with needle, sterile 3 ml                                           | By Report ea                   | N                  | 260 per 27-day period                  |               | Prior to 2/16/2015       | February 2015   |
| A4269                | N                                      | Syringe with needle, sterile 5 ml or greater                                | By Report ea                   | N                  | 260 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 aspirators, ear and oice bulb syringes)   | By Report ea                   | N                  | one per 365-day period                 |               | Prior to 2/16/2015       | February 2015   |
| A4215                | N                                      | Needle, sterile, any size, each                                            | By Report ea                   | N                  | 100 per 27-day period                  |               | Prior to 2/16/2015       | February 2015   |
| A4223                | N                                      | Intravenous administration set (with or without infusion pump), hypodermoclysis administration set, connecting device, heparin lock caps | By Report ea                   | N                  | 30 per 27-day period                   |               | Prior to 2/16/2015       | February 2015   |
Claim Formats

Electronic Claim Format

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

Excluded items must continue to be billed using the NCPDP Batch D.0/1.2 claim format:
- Diabetic testing supplies (test strips and lancets)
- Insulin syringes
- Peak flow meters and inhaler, assist devices
- Condoms
- Diaphragms and cervical caps
- Heparin and normal saline flush solutions
- Enteral nutritional formula

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

Paper Claim Format

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

Items excluded for billing on the CMS-1500 claim form include:
- Diabetic testing supplies (test strips and lancets)
- Insulin syringes
- Peak flow meters and inhaler, assist devices
- Condoms
- Diaphragms and cervical caps
- Heparin and normal saline flush solutions
- Enteral nutritional formula

HCPCS Level II codes cannot be billed on the Pharmacy Claim Form (30-1).
UPN Placement of UPN Product Qualifiers

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

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

UPNs are up to 19 digits in length.

UPN Qualifier and UPN Placement: CMS-1500 Claim Form

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

<table>
<thead>
<tr>
<th>24. A.</th>
<th>DATE(S) OF SERVICE</th>
<th>B. PLACE OF EMG</th>
<th>D. PROCEDURES, SERVICES, OR SUPPLIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FROM MM DD YY TO MM DD YY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>UK12345678901234</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>24. A. DATE(S) OF SERVICE</th>
<th>B. PLACE OF SERVICE</th>
<th>C. EMG</th>
<th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

UN00000030000
Reimbursement

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

Medi-Cal will pay the lesser of the:

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

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

Billing Tips for Service Code Groupings (SCGs)

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

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

Billing Tips for TARs and SARs

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

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

- A4212 – Huber needles
- A4215 – Pen needles
- A4223 – I.V. sets, connecting device, heparin lock caps. Does not include I.V. prep wipes, transparent dressings, I.V. start kits, etc. Refer to the provider manual for correct billing codes.
- A4322 – Irrigation syringe, regardless of how used (for example, used for feeding or irrigation 50 ml and over, common size 60 ml) when billing attachment does not describe the item otherwise.
- A4628 – Yankauers
- A9274 – Omni Pods, effective for dates of service (DOS) on or after September 1, 2018, refer to the DME provider manual for billing policy.
- B9999 – Empty I.V. bags, I.V. catheters, PICC supplies
- 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 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 include 1 additional type of pricing)
  - SWP – Suggested Wholesale Price
  - SWR – Suggested Wholesale Resale
  - Unit Price
  - Net Price
  - Quantity Discount
  - Case Price
- The front cover of catalog/price list must accompany the page if the individual page does not contain type of catalog pricing or date.

Invoice Reimbursement

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

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

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

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

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

Billing Using HCPCS Level II Procedure Codes:
**No UPN Required**
- If a price is listed on the formulary file, the system will price the claim using the above formulas
- If a price is not on the formulary file, the provider must attach a catalog page, price list or invoice for reimbursement. Claims will be processed using the formulas described in the “Reimbursement Calculation Formula” section above.

Billing Using HCPCS Level II Procedure Codes:
**Contracted, UPN Required**
- The provider must include the published contracted UPN on the claim in the appropriate section.
- The examiner will reimburse the UPN per the contracted one-each price described in the “Reimbursement Calculation formula” section above.
Guidelines B: TARs for Incontinence Supplies from the TAR Field Office

- Any manufacturer’s product that meets the description of the non-contracted HCPCS codes is eligible for reimbursement.

- Claims for “By Report” non-contracted HCPCS codes must include documentation of product cost (invoice, manufacturer catalog page or price list) as an attachment to the claim.

- Claims for non-contracted HCPCS codes with an MAPC do not require documentation of product cost (invoice, manufactured catalog page or price list) as an attachment to the claim.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description (Non-Contracted Supplies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4520*</td>
<td>Incontinence garment, any type, each, not elsewhere classified</td>
</tr>
<tr>
<td>T4529</td>
<td>Pediatric sized disposable brief/diaper, small/medium size, each</td>
</tr>
<tr>
<td>T4530</td>
<td>Pediatric sized disposable brief/diaper, large size, each</td>
</tr>
<tr>
<td>T4531</td>
<td>Pediatric sized disposable protective underwear/pull-on, small/medium size, each</td>
</tr>
<tr>
<td>T4532</td>
<td>Pediatric sized disposable protective underwear/pull-on, large size, each</td>
</tr>
<tr>
<td>T4534</td>
<td>Youth sized disposable protective underwear/pull-on (approved for weights up to 80 pounds)</td>
</tr>
<tr>
<td>T4543</td>
<td>Disposable brief/diaper, adult size bariatric or triple extra large (XXXL) and above</td>
</tr>
<tr>
<td>T4544</td>
<td>Disposable protective underwear/pull-on, adult size triple extra large (XXXL) and above *Effective April 1, 2015</td>
</tr>
</tbody>
</table>

* 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.
Medical Supplies

- 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:
    Washes: 960 ml per bottle
    Creams: 540 grams, weight may vary
    Provider is requesting for 2 bottles of wash for 12 months. The units on the TAR should be: 960 x 2 = 1,920 x 12 months = 23,040 units.
    For one (1) tube of cream at 540 grams: 540 grams x 12 months = 6,480 grams, or units.
Guidelines C: TARs for Medical Supplies from the TAR Field Office

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

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

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

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

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

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

**Electronic TARs (eTARs) and Keyed Data (Paper) TARs**
For eTARs and keyed data (paper) TARs, the quantity per month should equal the units requested (for example, for a provider requesting 30 catheters per month, quantity is 30/month, length of time is 6 months, units is 180). Providers can direct-bill for products without prior authorization as described in the provider manual and on the Medi-Cal website. Items for direct billing should not be included in the quantity per month.
**Nipple feeders**
Nipple feeders are medical supply items. Service code T5999 must be used. The provider must submit a CCS denial letter. Adjudication is based on medical necessity. Haberman feeders are Durable Medical Equipment (DME) items billed using code S8265.

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

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

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

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

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

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

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

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

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

Prescriptions that include “authorization period” will be approved. For example: if the prescription was signed and dated by the physician as of 7/28/14, the physician has signed an authorization period from 9/1/14 to 9/1/15, and the provider is requesting for these dates of service, the TAR may be approved from 9/1/14 to 8/31/15. If the provider’s date of service TAR request is to start 7/28/15, and the physician signed and dated the prescription 7/28/15 for an authorization period of 9/1/14 to 9/1/15, the TAR will be modified approved for dates 7/28/15 to 8/31/15. The prescription expires the day before the last authorized date.
Reauthorization requests
Providers must submit a brand new eTAR or keyed entry (paper) TAR for all reauthorization requests. Through dates of service cannot be extended. The TAR will be returned to the provider.

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

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

TARs: Miscellaneous
- A TAR requesting approval for an item or service that can be directly billed, and for which a TAR is not required, will be denied. A statement will be included in the “External Comment” area stating that the provider can directly bill the item or service without authorization if it is within the allowed frequency limit. Field office consultants will use this statement in the “External Comments” area: “This service does not require a TAR and may be direct-billed. Provider: do not reference the TAR number when billing for TAR free procedures.” This TAR denial does not apply if the request is for an overage amount.
- When a TAR is received for I.V. care supplies, peripherally inserted central catheter (PICC) line supplies, and/or central line supplies, specific physician’s orders are not required. Examples of I.V. supplies that have their own HCPCS procedure codes are: broad-spectrum skin antiseptics, translucent dressings, sterile gloves, gauzes, and betadine wipes.
- If the submitted TAR states “exceeded billing limitations” and the physician’s order can be billed directly, the TAR will be deferred for denial information or for a Remittance Advice Detail (RAD) to be submitted. TAR requests will be approved or modified for the overage amount of the direct bill HCPCS code.
- TAR requests that indicate the beneficiary is residing in an ICF/DD-H or ICF/DD-N home, or is under 5 years of age and receiving EPSDT services, can be approved for up to 12 months or until the prescription expires. Providers cannot bill directly for these. TARs are approved based on medical necessity. The incontinence supply prescription forms are acceptable formats for approving these TARs.
Guidelines D: 90-Day Frequency Limitations for Medical Supplies

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

Scenario 1

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

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

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

Scenario 2

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

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

Scenario 3

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

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

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

<table>
<thead>
<tr>
<th>RAD Code</th>
<th>Reason RAD Description</th>
<th>Billing Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>0005</td>
<td>The service billed requires an approved TAR <em>(Treatment Authorization Request)</em>.</td>
<td>1. Procedure code requires a TAR. 2. The quantity and frequency limits have been exceeded. 3. Units on TAR have been exhausted.</td>
</tr>
<tr>
<td>0010</td>
<td>This service is a duplicate of a previously paid claim.</td>
<td>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.</td>
</tr>
<tr>
<td>0225</td>
<td>This is an incorrect procedure code and/or modifier code for this service. Please resubmit.</td>
<td>Check provider manual to verify there is not a more specific HCPCS code for the item being billed.</td>
</tr>
<tr>
<td>0697</td>
<td>The drug/medical supply dispensed has exceeded the dispensing frequency limitation.</td>
<td>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.</td>
</tr>
<tr>
<td>9051</td>
<td>Indicate the quantity per box on the invoice.</td>
<td>Need to break down the quantity purchased on the invoice to the one-each price for reimbursement.</td>
</tr>
<tr>
<td>9098</td>
<td>The attached documentation is invalid. Refer to RAD code 0353 Billing Tip for additional information.</td>
<td>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.</td>
</tr>
<tr>
<td>9101</td>
<td>A copy of the manufacturer’s catalog page or supplier’s invoice is required.</td>
<td>No attachments were received with the claim. Attach a catalog page, price list or invoice to the claim.</td>
</tr>
<tr>
<td>9104</td>
<td>The attached invoice is illegible. Please resubmit.</td>
<td>Copy is bad. Adjust copy machine to produce a clear copy.</td>
</tr>
<tr>
<td>9217</td>
<td>Indicate a line number next to the catalog number.</td>
<td>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.</td>
</tr>
<tr>
<td>RAD Code</td>
<td>Reason RAD Description</td>
<td>Billing Tips</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------</td>
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</tr>
<tr>
<td>9251</td>
<td>The service billed requires a product-specific SAR (Service Authorization Request). Please contact your local CCS (California Children's Services) office.</td>
<td>Provider has exceeded the frequency and/or quantity limits for Medi-Cal. Service grouping SARs cannot be used for items over the limits.</td>
</tr>
<tr>
<td>9556</td>
<td>Either the invoice or the certification is missing or invalid.</td>
<td>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.</td>
</tr>
<tr>
<td>9670</td>
<td>Claim date of service does not match date of service on SAR (Service Authorization Request) file.</td>
<td>Verify span date on SAR authorization with DOS (Date of Service).</td>
</tr>
<tr>
<td>9671</td>
<td>Procedure code has not been authorized by CCS/GHPP (California Children’s Services/Genetically Handicapped Persons Program).</td>
<td>Verify procedure code being billed is listed on authorization.</td>
</tr>
<tr>
<td>9713</td>
<td>The date on the catalog or invoice is missing or invalid.</td>
<td>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.</td>
</tr>
<tr>
<td>9897</td>
<td>HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is missing.</td>
<td>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.</td>
</tr>
<tr>
<td>9898</td>
<td>HCPCS Qualifier and NDC (National Drug Code)/UPN (Universal Product Number) is invalid.</td>
<td>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.</td>
</tr>
</tbody>
</table>
Resource Information

References

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

Part 2

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

Other References
Medi-Cal website (www.medi-cal.ca.gov)
Medi-Cal bulletins
Medi-Cal Learning Portal: Online Tutorials
## Appendix

### Acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
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<tr>
<td>BIC</td>
<td>Benefits Identification Card</td>
</tr>
<tr>
<td>CA-MMIS</td>
<td>California Medicaid Management Information System</td>
</tr>
<tr>
<td>CCN</td>
<td>Claims Control Number</td>
</tr>
<tr>
<td>CCS/GHPP</td>
<td>California Children's Services and Genetically Handicapped Persons Program</td>
</tr>
<tr>
<td>CHDP</td>
<td>Child Health and Disability Prevention</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>CMC</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CRTS</td>
<td>Certified Rehabilitation Technology Supplier</td>
</tr>
<tr>
<td>CSU</td>
<td>Correspondence Specialist Unit</td>
</tr>
<tr>
<td>DHCS</td>
<td>Department of Health Care Services</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>EAC</td>
<td>Estimated Acquisition Cost</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal Intermediary, contractor for DHCS responsible for claims processing</td>
</tr>
<tr>
<td>HAP</td>
<td>Health Access Programs</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>ICD-10</td>
<td>International Classification of Diseases – 10th Revision</td>
</tr>
<tr>
<td>LPM</td>
<td>Liters Per Minute</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>LSRS</td>
<td>Lab Service Reservation System</td>
</tr>
<tr>
<td>MAC</td>
<td>Maximum Allowable Product Cost</td>
</tr>
<tr>
<td>MAPC</td>
<td>Maximum Allowable Product Cost</td>
</tr>
<tr>
<td>MNIHA</td>
<td>Medicare Necessary Interperiodic Health Assessment</td>
</tr>
<tr>
<td>MSRP</td>
<td>Manufacturer’s Suggested Retail Price</td>
</tr>
<tr>
<td>MUE</td>
<td>Medically Unlikely Edit</td>
</tr>
<tr>
<td>NCCI</td>
<td>National Correct Coding Initiative</td>
</tr>
<tr>
<td>NF</td>
<td>Nursing Facility (Level A or B)</td>
</tr>
<tr>
<td>NCPDP</td>
<td>National Council for Prescription Drug Programs</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>NDC</td>
<td>National Drug Code</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
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<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>O&amp;T</td>
<td>Orthotics &amp; Prosthetics</td>
</tr>
<tr>
<td>POS</td>
<td>Point of Service</td>
</tr>
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<td>PT</td>
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