



### Allied Health • Durable Medical Equipment & Medical Supplies

#### November 2006 • Bulletin 373

##### Contents

<i>Opt Out Enrollment Form</i>	
<i>Medi-Cal Training Seminar</i>	
Revised UPN Medical Supply Pilot Implementation Plan.....	1
Oxygen and Related Equipment Policy Update .....	2
Disposable Gloves Billing Update .....	4
HCBS Billing Changes.....	5
Rate Corrections for Selected Orthotics .....	5
California Children’s Services Modifier Update .....	6
Corrections: DME Items Reimbursable Only to CCS Providers.....	6

#### Revised UPN Medical Supply Pilot Implementation Plan

Beginning January 1, 2008, the California Department of Health Services (CDHS) is planning to implement the Medical Supply Universal Product Number (UPN) Pilot in two phases.

Phase I: Implementation of batch claims processing via Computer Media Claims (CMC), Internet Professional Claims Submission (IPCS) and paper claim processing. The implementation date is January 1, 2008.

Phase II: Implementation of online real-time claims processing via IPCS, Point of Service (POS) device (ASC X12N 837 v.4010A1 Professional transaction) and POS network leased line and dial-up. This phase will also include batch claims processing via the POS device for 837 Professional transactions. The implementation date is July 1, 2008.

#### Background

The Health Insurance Portability and Accountability Act (HIPAA) mandates the use of HCPCS Level II codes on electronic medical supply claims. As a result, CDHS plans to discontinue all interim medical supply codes and convert to HCPCS Level II codes. Due to the generic nature of the HCPCS Level II codes, CDHS requested, and was granted, an exception to the HIPAA standards by the Centers for Medicare and Medicaid Services (CMS). The exception allows for the use of the UPN as part of a two-year pilot for billing and payment of medical supplies within the following four product categories:

- Urinary catheters and bags (urologicals)
- Incontinence supplies
- Ostomy care products
- Wound care products

CDHS will seek volunteers to participate in the UPN pilot. Some of the advantages of participating in the UPN pilot include:

- Online real-time claims processing and immediate claim status notification. This feature will be available beginning July 1, 2008.
- No requirement to submit pricing attachments (via batch or online real-time).
- Improved speed and accuracy of claim payments.

Providers who choose not to participate in the UPN pilot will be required to bill HCPCS Level II codes on all medical supply claims. The majority of these claims will continue to require pricing attachments, and online real-time claims processing will not be available.

### Oxygen and Related Equipment Policy Update

Legislation was signed July 12, 2006, amending *Welfare and Institutions Code*, Section 14105.48, specifying that effective for dates of service on or after January 1, 2007, reimbursement for oxygen delivery systems and oxygen contents shall utilize national HCPCS codes.

Therefore, effective for dates of service on or after January 1, 2007, the following coverage and reimbursement policy changes will be implemented:

#### TAR Requirement

All requests for oxygen delivery systems, oxygen contents and related equipment will require a *Treatment Authorization Request (TAR)*, which must be sent to the Fresno Medi-Cal Field Office. Authorization for oxygen therapy will be granted for the lowest cost delivery system that best meets the recipient's medical needs. Providers may need to request corrections to currently authorized TARs or submit new TARs for dates of service on or after January 1, 2007.

#### Reimbursement

Reimbursement rates for oxygen therapy services will be the lesser of the amount billed or 80 percent of the lowest maximum allowance of the California Medicare reimbursement rate for the same or similar item or service. Rates will be adjusted for the following HCPCS codes: A4615, A4620, E0424, E0425, E0430, E0441, E0442, E1353 and E1355.

#### Procedure Codes

The following HCPCS Level II oxygen delivery systems and oxygen contents procedure codes will be new benefits covered by Medi-Cal:

E0439, E0440, E0443, E0444, E1392\*

\* This code will be activated with the 2006 HCPCS annual update effective for dates of service on or after November 1, 2006.

The descriptors for the following currently covered HCPCS Level II oxygen delivery system and oxygen contents procedure codes will be revised from local descriptors to national descriptors. Policy will be revised accordingly:

E0424, E0441 and E0442

All other currently covered benefits will remain in effect.

#### “One Unit of Oxygen” Redefined

One unit of oxygen equals “one month's supply,” regardless of how many pounds or cubic feet of oxygen are supplied. This change in the definition of “one unit of oxygen” affects codes E0441, E0442, E0443 and E0444.

#### Modifiers

The following three new HCPCS Level II modifiers are to be used only with stationary gaseous (E0424) or liquid (E0439) systems or with a non-portable oxygen concentrator (E1390, E1391). These modifiers are not reimbursable with any other codes.

- QE Prescribed amount of oxygen is less than one liter per minute (LPM). The reimbursement amount is reduced by 50 percent.
- QF Prescribed amount of oxygen is greater than four liters per minute and portable oxygen is also prescribed. The reimbursement amount is increased by 50 percent.
- QG Prescribed amount of oxygen is greater than four liters per minute and portable oxygen is not prescribed. The reimbursement amount is increased by 50 percent.

Please see **Oxygen**, page 3

**Oxygen** (*continued*)**Criteria**

Medi-Cal covers oxygen therapy for recipients who meet the established medical criteria. The requirements for establishing the medical necessity for oxygen are listed below.

- A. Laboratory evidence of hypoxemia in the chronic stable state or exercise induced hypoxemia **and a prescription** from the recipient's physician specifying all of the following information must be submitted with the request for prior authorization:
1. The diagnosis or medical condition requiring supplemental oxygen
  2. The oxygen flow rate requested
  3. An estimate of the frequency (hours per day) and duration of use (months)

A prescription for "Oxygen prn" or "Oxygen as needed" is unacceptable.

Initial requests for oxygen must include a recent arterial blood gas (ABG) report (obtained within 30 days of the request), unless the recipient is unable to tolerate the test, in which case an oximetry study is satisfactory. However, documentation from a physician must be submitted explaining the rationale for submission of an oximetry study instead of an ABG.

Supplemental oxygen requests require that the recipient's arterial partial pressure of oxygen ( $Pa_{02}$ ) must be 55 mm Hg or less, or the oxygen saturation ( $Sa_{02}$ ) must be 88 percent or less with the test taken on room air in the chronic stable state and, if hospitalized, no more than two days prior to hospital discharge.

If the arterial  $Pa_{02}$  is 56-59 mm Hg or the  $Sa_{02}$  is 89 percent, a secondary diagnosis is necessary, such as but not limited to: congestive heart failure, cor pulmonale or erythrocytosis/erythrocythemia. Medi-Cal Field Office consultants who are reviewing the medical necessity for supplemental oxygen use will take into consideration that the laboratory specified values above may vary due to factors such as a recipient's age, or the altitude level at which the test was taken.

If the arterial  $Pa_{02}$  is equal to or greater than 60 mm Hg or the  $Sa_{02}$  is equal to or greater than 90 percent, the medical necessity for oxygen is unlikely to be established. However, individual cases submitted with detailed documentation substantiating medical necessity will be evaluated on a case-by-case basis.

For pediatric recipients an oximetry study with  $Sa_{02}$  submitted with the TAR is satisfactory. No ABG is required. Requests for supplemental oxygen for pediatric recipients with a  $Sa_{02}$  of 90 mm Hg or greater will be considered on a case-by-case basis. Requests for supplemental oxygen for children with medical conditions covered by California Children's Services (CCS) should be submitted to the appropriate CCS county office for approval.

- B. A stationary oxygen system will be authorized unless the recipient's need to pursue usual activities with a portable oxygen system is established with the submitted documentation.
- C. If the recipient's need for supplemental oxygen changes, the recipient's physician must update the medical documentation and laboratory evidence accordingly, and the oxygen and related equipment provider must submit the new data with a new TAR.

*Please see **Oxygen**, page 4*

**Oxygen** (*continued*)

- D. If the supplemental oxygen system requested is not the lowest cost system which will meet the recipient's medical needs, Medi-Cal will modify the request. If oxygen is used for less than 24 hours per day, Medi-Cal may pro-rate the reimbursement to reflect less than 24 hours per day utilization of oxygen. If there is medical necessity which justifies a recipient's use of a higher cost supplemental oxygen system, it must be documented in detail by the prescribing physician. If a higher cost system is requested only for the recipient's and/or provider's convenience, the TAR may be authorized but reimbursement will be at the rate of the lowest cost item.
- E. If a patient qualifies for additional payment for greater than four LPM and also meets the requirements for portable oxygen (E0431 or E0434), payment will be made for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied.
- F. Monthly rental and reimbursement for purchased oxygen concentrators (E1390, E1391 and E1392) include all accessories, delivery and set-up. A portable gaseous system may be added if there is a documented need for mobility or exercise.
- G. After one year of oxygen therapy, re-certification is required for continued use. The request must include a recent ABG report (obtained within 30 days of the request), unless the recipient is unable to tolerate the test, in which case an oximetry study is satisfactory. However, documentation from a physician must be submitted explaining the rationale for submission of an oximetry study instead of an ABG.

More information will appear in a future *Medi-Cal Update*.

**Disposable Gloves Billing Update**

The California Department of Health Services has negotiated new contracts with manufacturers of disposable gloves and, effective for dates of service on or after February 1, 2007, will change the way providers bill for disposable gloves.

Effective for dates of service on or after February 1, 2007, providers must bill disposable gloves with the billing codes noted on pages 24 through 37 of the *Medical Supplies List 1 (A through G)* section. All other manufacturers' products not included in a contract will no longer be a benefit of the Medi-Cal program. Providers who obtained *Treatment Authorization Requests* (TARs) prior to February 1, 2007 for non-contracted items will be allowed to continue billing these items until their TAR authorization is exhausted.

Effective for dates of service on or after November 1, 2006, providers may begin purchasing disposable gloves at the new Medi-Cal Maximum Acquisition Cost (MAC). Providers should bill these contracted products using the current payment method, using billing codes 9911A or 9911B.

*Please see **Gloves**, page 5*

Gloves (*continued*)

During the three-month transition period between dates of service of November 1, 2006 and January 31, 2007, providers may also bill any non-contracted products using the current payment method.

The existing restriction of no more than 200 gloves in a 27-day period, per recipient, without prior authorization, and the limit of 100 per prescription remain unchanged.

**Disposable Glove Addition**

Effective for dates of service on or after February 1, 2007, the Cardinal (2N) disposable glove is a Medi-Cal authorized product.

*These changes are reflected on manual replacement pages mc sup lst1 24 thru 37 (Part 2).*

**HCBS Billing Changes**

**Waiver Updates**

Effective for dates of service on or after November 1, 2006, in compliance with HIPAA, the California Department of Health Services will allow only HCPCS Level II codes and modifiers when billing for the Home and Community-Based Services (HCBS) waiver program. HCPCS Level III codes and modifiers will no longer be reimbursable by Medi-Cal. More information will be available in future *Medi-Cal Updates*.

**Note:** For HCBS waiver services that have been previously authorized, HCPCS Level III codes and modifiers will be paid for dates of service up to May 31, 2007.

For more information, in-state providers may call the Telephone Service Center at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200.

**Rate Corrections for Selected Orthotics**

Reimbursement rates for the following orthotic appliances were listed incorrectly in the October 2006 *Medi-Cal Update*. The correct rates, which are effective for dates of service on or after November 1, 2006, are listed below.

<u>HCPCS Code</u>	<u>Description</u>	<u>Rate</u>
L2036	Full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom fabricated	\$ 943.12
L2037	Full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated	943.12
L2038	Full plastic, double upright, with or without free motion knee, multi-axis ankle, custom fabricated	811.87
L3215	Ladies shoe, oxford, each	42.12
L3971	Molded shoulder, arm, forearm, and wrist, with articulating elbow joint, custom fabricated	1,077.21

*Corrected rates are reflected on manual replacement pages ortho cd1 15, 21 and 29 (Part 2).*

**California Children's Services (CCS) Modifier Update**

Effective for dates of service on or after November 1, 2005, California Children's Services (CCS) modifiers for Durable Medical Equipment (DME), hearing aids and hearing aid accessories and services were revised in compliance with HIPAA.

The following interim modifiers were terminated:

- Y1 (rental without sales tax [DME, hearing aids])
- Y2 (purchase, repair, mileage, without sales tax [standard item; DME, hearing aids])
- Y5 (purchase, less one month's rental, without sales tax [DME])
- Y6 (rental with sales tax [DME, hearing aids])
- Y7 (purchase, repair, mileage, with sales tax [standard item; DME, hearing aids])
- YP (purchase, less one month's rental, with sales tax [DME])

Claims for all DME codes and hearing aid and accessories codes must now be billed with national modifier NU (new equipment purchase), RP (repair) or RR (rental), as appropriate.

*This information is reflected in the CCS Program Billing Guidelines chart (Part 2) and on manual replacement pages cal child sar 8 (Part 2) and hcpcs 1 (Part 2).*

**Corrections: DME Items Reimbursable Only to CCS Providers**

HCPCS codes A4606 (oxygen probe), E0639 and E0640 (patient lifts) were incorrectly included in the *Durable Medical Equipment (DME) Billing Codes: Frequency Limits* section of the manual.

These codes are not reimbursable for adult Medi-Cal recipients and should not have been included in that manual section. The codes are reimbursable only for CCS clients. They have been correctly listed in the *Durable Medical Equipment (DME): Billing Codes for California Children's Services (CCS)* section.

*Corrections are reflected on manual replacement pages dura cd ccs 1 (Part 2) and dura cd fre 1 and 2 (Part 2).*

**November 2006**

---

---

**Durable Medical Equipment & Medical Supplies Bulletin 373**

Remove and replace  
at the end of the  
*California Children's  
Services (CCS)  
Program Billing*  
section:

*CCS Program Billing Guidelines*

Remove: cal child sar 7 thru 9

Insert: cal child sar 7/8

Remove and replace: cal child ser 1/2 \*

Insert: cal child ser 23 \*

Remove and replace: dura cd ccs 1  
dura cd fre 1/2  
forms leg 3/4 \*  
hcpcs 1/2  
mc sup lst1 23 thru 37  
mc sup man cd 3/4 \*  
ortho cd1 15/16, 21/22, 29/30

\* Pages updated due to ongoing provider manual revisions.