



DME Bulletin

Vol. 5 No. 1 • Winter 2008-09



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Save the Date!

DME, Hearing Aid and Orthotic/Prosthetic Workshop

Thursday, May 7, 2009
Santa Maria Inn

UPCOMING WORKSHOP

Please be advised that the CenCal Health annual DME, Hearing Aid and Orthotic / Prosthetic Workshop has been scheduled for Thursday, May 7, 2009, at the historic Santa Maria Inn in Santa Maria. Due to the ongoing budget constraints, we will be holding only one workshop for both Santa Barbara and San Luis Obispo County providers, so we are using a location in the middle of our service area in order to accommodate all providers. Please look for your invitation to this informative event in April. If you have any questions in the meantime or would like to suggest a topic of interest to be covered, please contact Jennifer Fraser, your DME Provider Services Representative, at (805) 685-9525, extension 1674.

JIM ST. OURS, DME UTILIZATION SPECIALIST, RETIRES

After eight years of service, Jim St. Ours, CenCal Health's DME Utilization Specialist, has retired. His last day with the organization was December 30th. During his tenure at CenCal Health, Jim had been the reviewer of prior authorizations for DME, hearing aids, orthotics and prosthetics. His vast experience and knowledge in the field of durable medical equipment has been a great asset to the organization in defining and streamlining the DME benefits under our programs. Jim will be greatly missed by CenCal Health staff as well as our provider network for his efficiency and quirky sense of humor. Please join us in congratulating Jim on his retirement and wishing him much happiness as he travels the country in his new motor home. Good luck, Jim, and be sure to send us a postcard!



MODIFIERS FOR POWER WHEELCHAIRS, INTERFACES AND ACCESSORIES

- **Power Wheelchairs: HCPCS codes E1239, K0010, K0011, K0012 & K0014**

These procedure codes are restricted to repairs only and must be billed with modifier RP (repair/replacement). Documentation or remarks in Box 19 of the CMS-1500 claim form that states the repair is for patient owned equipment is also required. If these codes are billed with modifiers NU (purchase) or RR (rental), the claim will be denied.

- **Power Wheelchair Interface: HCPCS codes E2312, E2321, E2322, E2327 & E2373**

Claims billed with these procedure codes must be billed with a NU, RR or KC (replacement of special power wheelchair interface) modifier. Documentation or remarks in Box 19 of the CMS-1500 form that states the repair is for patient owned equipment is also required. If these codes are billed with modifier KC, claims must be billed in a specific modifier order:

Modifier order for patient-owned power wheelchair: RP, NU, KC

Modifier order for power wheelchair rental: RR, KC

- **Power Wheelchair Accessories: E2374 – E2376 & E2381 – E2397**

These procedure codes may only be reimbursed as purchased replacement items for patient-owned equipment. Claims must be billed with modifiers RP and NU. If modifier NU is listed first, the claim will be denied. Documentation or remarks in Box 19 of the CMS-1500 form that states the repair is for patient owned equipment is also required.

MODIFIERS ON MEDICARE ELECTRONIC CROSSOVER CLAIMS

Medicare requires some of the replacement procedure codes to be billed with the NU modifier first, but for Medi-Cal, modifier RP must be listed first. Our system will not systematically identify the secondary or any additional modifiers as well as it will not change them to the appropriate format. Any additional modifier will be manually reviewed by CenCal Health staff. To avoid modifier denials on your claims, providers must submit the appropriate modifier format as a correction to:

CenCal Health
Claims Department
110 Castilian Drive
Goleta, CA 93117

PRESCRIPTION (RX) DOCUMENTATION

Durable medical equipment (DME), medical supply, hearing aid and orthotic / prosthetic providers are required to obtain a prescription from the member's Primary Care Provider (PCP) or other qualifying physician. *Any qualified physician can write a prescription for a CenCal Health member.*

The physician prescription does not need to be attached to the claim; it should be placed in the member's medical chart. From time to time, CenCal Health staff will audit our providers to ensure the prescription is indeed on file.

When billing for products requested through a prescription, providers must include a remark in the "Reserved for Local Use" section (Box 19) of the CMS-1500 claim form. Please include the name of the physician as well as their provider number. For example, the following verbiage is appropriate for indicating a prescription is on file:

- Prescription on file from Dr. "Full Name", NPI 1234567890

If you have any questions regarding the prescription requirement, please contact your Claims Representative.

INTRODUCTION OF DIANNE SWENSON, RN

We would like to introduce to you Dianne Swenson, RN who has taken over the responsibilities of reviewing prior authorizations for Jim St. Ours. Dianne started with CenCal Health



in September 2008 and was hired specifically to perform facility site and medical review audits at our network physician offices. In January, she added to her responsibilities the authorization review for DME, hearing aids, orthotics and prosthetics. Dianne is a registered nurse (RN) with a MBA. She brings with her extensive experience in facility site and medical review audits as well as utilization management. She currently lives in Camarillo with her family.

Please join us in welcoming Dianne to her expanded role at CenCal Health. Any questions regarding prior authorizations for DME, hearing aids, orthotics and prosthetics can be directed to her attention at extension 1628.

TRANSITION TO HCPCS LEVEL II CODES FOR MEDICAL SUPPLIES

Effective for date of service (DOS) on or after April 1, 2009, the Department of Health Care Services (DHCS) is mandating changes in procedure codes for disposable and incontinence medical supplies. These changes include requirements for the use of the national Healthcare Common Procedure Coding System (HCPCS) Level II codes from the local “99” codes. A ninety (90) day grace period has been allowed for previously approved Treatment Authorization Requests (TARs) that have authorization “thru” dates beyond April 1, 2009.

Below is CenCal Health’s policy for transition to HCPCS Level II codes for prior authorization and claims submission. Dual lines on TARs, submission of both the local “99” code and the HCPCS Level II code, is voluntary prior to March 31, 2009; however, dual lines are required for service periods after April 1, 2009 but prior to June 30, 2009, if still using the “99” local code.

Treatment Authorizations Requests (TARs)

• **Previously Authorized TARs:**

- “Thru” Dates Prior to June 30, 2009 – TAR is valid with the local “99” code. No action is needed.
- “Thru” Dates Beyond June 30, 2009 – a new TAR using the new HCPCS Level II code will need to be submitted to cover the remaining service period beyond June 30, 2009. Please enter in the Medical Justification field “Code Conversion” on the new TAR form (paper or electronic). It is not necessary to include the previous TAR number.

• **New TAR Submission:**

- “Thru” Date Prior to April 1, 2009 – submission of TAR requires the local “99” code
- “Thru” Dates After April 1, 2009 but Prior to June 30, 2009 – submission of TAR requires dual lines if billing the local code (the local “99” code as well as the HCPCS Level II code); however, TARs may be submitted with only the HCPCS Level II code during this time period.
- “Thru” Date After June 30, 2009 – submission of TAR requires dual lines if billing the local code (the local “99” code as well as the HCPCS Level II code); however, TARs may be submitted with only the HCPCS Level II code during this time period. A new TAR is not required to be submitted.

TAR Effective Dates	Code Required
Prior to April 1, 2009	Local Code only
After April 1, 2009 but Prior to June 30, 2009	Local Code & HCPCS (dual lines); or HCPCS only
After June 30, 2009	HCPCS only

Claims Submission

The local “99” codes may continue to be billed to CenCal Health with a DOS on or before June 30, 2009. The HCPCS Level II codes are only reimbursable for DOS on or after April 1, 2009, and must be billed on the CMS 1500 claim form only. HCPCS cannot be submitted using the Medical Supply claim form. Submission of a local “99” code with a DOS on and after July 1, 2009 will result in a denial of the claim. Claims denied for this reason will be indicated with an Explain Code of 88 (Procedure Code Replaced by HIPAA Compliant Code) on your Explanation of Benefits (EOB). A correction will need to be mailed to CenCal Health with the appropriate code for the claim to be payable. *Please note: the procedure code on the claim must match the procedure code on the TAR in order for the prior authorization to be valid. If a TAR contains dual lines (one for the local code and one for the HCPCS code), please bill the appropriate code based on the DOS. **Please do NOT bill for both the local code and the HCPCS code.***

Claims DOS	Code Required
Prior to April 1, 2009	Local Code only
After April 1, 2009 but Prior to June 30, 2009	Local Code & HCPCS (dual lines); or HCPCS only
After June 30, 2009	HCPCS only

For more information on this transition to HCPCS Level II codes including a procedure code correlation spreadsheet, you may access Medi-Cal’s website at www.medi-cal.ca.gov. If you have any questions regarding the TAR transition for CenCal Health members, please contact the Health Services Department at extension 1628 or the Provider Services Department at extension 1674. For any questions on claims submission during this transition, please contact your Claims Representative at extension 1061.

CHARPENTIER BILLING PROCESS

The Charpentier Injunction provides for additional reimbursement to providers of custom and power wheelchairs beyond Medicare's deductible and co-payment amounts if Medi-Cal's allowable amount was greater than Medicare's allowable. For DME covered under Charpentier, providers should submit a Charpentier TAR if the item(s) would normally require a TAR and indicate that it is a Charpentier TAR in the Medical Justification section.

Providers must first bill Medicare and any other health coverage (OHC) the member may have and wait for Medicare and/or the OHC to pay the claim before submitting the crossover claim to Medi-Cal. After the crossover claim has been processed by CenCal Health, the Charpentier rebill claim may then be submitted for the difference in the allowable dollar amount or the difference in the benefit limitation or both if applicable. The Charpentier rebill claim should be billed with the Medi-Cal procedure code which most closely reflects the goods/services provided and which most closely equates to the Medicare code originally billed to Medicare and shown on Medicare's EOMB.

In addition, the words "Medi-Medi Charpentier: Rates" or "Medi-Medi Charpentier: Benefit Limitation" or "Medi-Medi Charpentier: Both Rates and Benefit Limitation" must appear in Box 19 of the claim form. The sum of any previous payments from Medicare, Medi-Cal (crossover claim payment) and OHC must be entered on the claim form in Box 11d. Please select one of the following letters that corresponds to the phrase entered in Box 19: Rates ="R", Benefit Limitation ="L", Both Rates & Benefit Limitations ="T", and enter that letter in Box 22. If fewer claim lines are being rebilled to Medi-Cal, indicate with an asterisk on the Medicare EOMB the items that are being rebilled. Attachments to the rebill claim must include copies of the following:

- (1) the original CMS 1500 billing sent to Medicare;
- (2) the Medicare EOMB, the Medi-Cal and/or OHC EOB showing crossover and/or an OHC payment made, or a denial from OHC if applicable;
- (3) the TAR, if applicable, and
- (4) the catalog page and pricing documentation if for a "By Report" item.

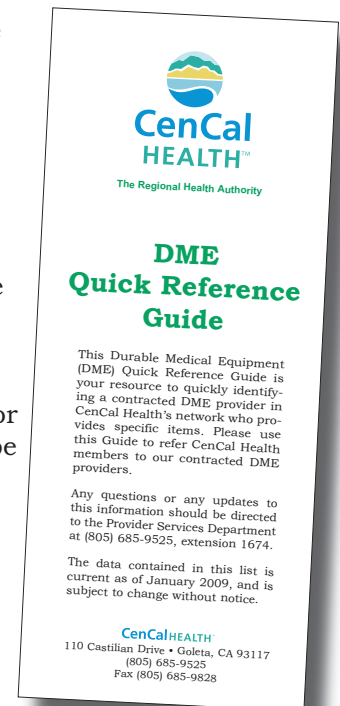
If you have any questions on billing for Charpentier items, please contact your Claims Representative at extension 1061.

AUTHORIZATION INFORMATION ON CLAIM FORMS

Prior authorization is required for durable medical equipment (DME), orthotic and prosthetic items based on exceeding a monetary threshold. Prior authorization for medical supply items is based on a unit limitation set forth in the Medi-Cal Manual. Authorizations (TAR/ARs) are required to be included on the claim form (CMS-1500) in the authorization field or Box 23. If a phrase is entered into Box 23, i.e., "AUTH N/A" or "AUTH NOT REQ", our system will not recognize it and will deny or suspend the claim for review thereby causing delays in your payment. Only a valid TAR/AR number should be entered into Box 23. If an authorization is NOT required for the item being billed, please leave Box 23 empty. Any questions regarding the authorization field on the CMS-1500 claim form can be directed to your Claims Representative.

DME QUICK REFERENCE GUIDE

To assist our provider network as well as internal staff in making referrals for durable medical equipment and medical supplies, CenCal Health publishes a DME Quick Reference Guide listing information on our contracted DME network in regards to their products and services. In February, the Guide was finalized and sent to the CenCal Health provider network. If you did not receive your copy, please contact Jennifer Fraser, the DME Provider Services Representative, to request a copy or make any changes for the next printing. She can be reached at (805) 685-9525, extension 1674. We value the diversity of products provided through our DME network and thank you for your continued commitment to all CenCal Health members.



HOLIDAY CLOSURES

CenCal Health will be closed on Monday, May 25th in observance of Memorial Day.