MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Home Health Agencies 01-06

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Subject: Uniform Billing
Revised Chapter IV
Procedure Code Appendix

Effective: February 1, 2002

Programs Affected: Medicaid, Children's Special Health Care Services

PURPOSE

Effective February 1, 2002, the Michigan Department of Community Health (MDCH) is implementing changes in coverage, reimbursement policies, and claim submission requirements for home health agencies as part of its Uniform Billing Project (UBP). These changes will align MDCH requirements with those of other major health insurers and are a step toward HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance. This bulletin, and the revised accompanying Chapter IV, reflect these changes.

Chapter III of the Medicaid Home Health Manual will be revised at a later date to reflect changes in policy related to the UBP. These changes include:

- elimination of Michigan Local Codes (new billing codes are located in the attached Procedure Codes Appendix),
- elimination of reimbursement for staff mileage (this is discussed later in this bulletin), and
- change in billing instructions for postpartum/newborn visits (new billing instructions are located in the attached Chapter IV, Section 3).

Note: Policies not related to the UBP remain in effect.

Copies of all draft or final policy bulletins, the electronic claim transaction set, and other information related to changes being made are available on the MDCH website at www.mdch.state.mi.us, *click on Medical Services Administration, Information for Medicaid Providers.*

CLAIM FORMATS

You may submit your claims electronically or on paper. However, electronic claim submission is the method preferred by MDCH. Claims submitted electronically are entered directly into the Claims Processing System resulting in faster payments, and fewer pends and rejects. Claims can be submitted by file transfer or through the data exchange gateway.

The preferred electronic format is the Michigan Medicaid Interim Version of the National Electronic Data Interchange Transactions Set Health Care Claim: Institutional 837 (ASC X12N 837, version 4010). Up to the HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance effective date, MDCH will also accept the UB-92 EMC 5.0.

Information on submission of electronic claims using the Michigan Medicaid Interim Institutional Version 4010 (ASC X12N 837) format is available on the DCH website at: www.mdch.state.mi.us, click on Medical Services Administration, Information for Medicaid Providers, Uniform Billing.

To submit electronic claims using the UB-92 EMC 5.0, see the revisions to the Medicaid Electronic Billing Manual. These revisions are being sent to all providers that currently have an active electronic billing ID number with MDCH. If you do not currently bill electronically, contact the Automated Billing Coordinator for the MDCH. Until the revised Electronic Billing Manual is available, use the billing instructions in the UB Manual and the Medicaid Home Health Manual, Chapter IV.

For more information on electronic billing:

E-mail: AutomatedBilling@state.mi.us

Or write to:

Michigan Department of Community Health
Medicaid EDI Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

NOTE: Currently, the MDCH has a cooperative agreement with Blue Cross and Blue Shield of Michigan (BCBSM) that allows home health agencies to use the BCBSM EPIC system to submit Medicaid home health claims. BCBSM will forward these claims to MDCH within one business day. For additional information, contact BCBSM at (248) 486-2445.

If you submit claims on paper, the UB-92 claim form must be used. Paper claim completion instructions are contained in the attached Chapter IV.

Home health agencies must use the UB-92 paper claim form (HCFA 1450) or one of the two associated electronic claim formats on and after February 1, 2002. These formats must be used regardless of the date of service. These formats must also be used for adjusting services on and after February 1, 2002, even though services may have been previously paid under the old formats.

Testing of paper and electronic claim formats began in November 2001 and will continue through January 31, 2002. This testing period will allow home health agencies and the MDCH time to detect and correct any problems that might occur with the conversion to the new formats. A letter indicating the instructions for claims testing was issued to Home Health providers in October. Copies of the testing instructions are available on the DCH website.

BILLING INSTRUCTIONS

Home health agencies must use the UB-92 Uniform Billing (UB) Manual for completing the UB-92 claim form. Medicaid billing instructions for completing the UB-92 will be incorporated into the UB-92 Uniform Billing Manual, along with Medicaid claim examples. The attached Medicaid Home Health Agency Manual Chapter IV, Section 3, contains additional information on the UB-92 Uniform Billing Manual. This chapter has also been reformatted and updated to conform with Medicaid's current processes and information related to billing and reimbursement.

In the event the agency needs a UB-92 Uniform Billing Manual, one can be obtained as instructed in the attached Chapter IV, Section 1.

In addition to the above, the home health agency should note:

- Medicaid will follow Medicare's policy of reporting services in 15-minute increments. Chapter IV, Section 3, details Medicaid policy.

- Medicaid follows Medicare policy on the requirement that each home health agency visit (e.g., nursing, therapy) must be billed on an individual line. This policy includes two visits performed on the same day (i.e., two visits on the same day must be billed on individual lines).

- The billing instructions for postpartum/newborn visits have been changed. The provider is to ignore the instruction in Chapter III of the Home Health Agency Manual. The provider should use the billing instructions in the attached Chapter IV, Section 3.

PROCEDURE CODES

Effective for all claims received on and after February 1, 2002, services must be billed on the new claim formats with Revenue Codes and supporting procedure codes. Many of the procedure codes are from the Health Care Financing Administration Common Procedure Coding System (HCPCS). The procedure codes are listed in the attached Procedure Codes Appendix.

Effective on and after February 1, 2002, home health agencies are NOT to bill using the local codes listed in Appendix G of the Medicaid Home Health Manual. **Exception:** See mileage below.

ELIMINATION OF SEPARATE REIMBURSEMENT FOR STAFF MILEAGE

For dates of service on and after February 1, 2002, the Department of Community Health will no longer separately reimburse for home health mileage. These changes will bring the Department of Community Health in line with how other insurers reimburse for home health services.

Note: For mileage for dates of service prior to February 1, 2002, the provider must bill Revenue Code 589 and Procedure Code 70114.

EXPLANATION CODES

The following explanation codes were developed as a result of the UBP. These explanation codes and descriptions should be added to the Explanation Code Appendix of the Medicaid Home Health Agency Manual.

971 Supporting HCPCS code is invalid or missing.

972 Medicare pays 100% of the service. The service must not be rebilled to Medicaid.

MANUAL MAINTENANCE

The attached Chapter IV is for use for claims submitted on and after February 1, 2002, and should be inserted into the manual at that time. The provider may wish to retain the existing Chapter IV for reference.

The home health agency may discard MSA 01-17 bulletin. Effective February 1, 2002, replace the current Appendix G with the attached Procedure Codes Appendix.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@state.mi.us. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVED

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INTRODUCTION

This chapter contains information needed to submit claims to the Michigan Department of Community Health (MDCH) for Medicaid and Children's Special Health Care Services (CSHCS). It also contains information on claims processing.

Providers are encouraged to bill electronically to receive faster payment and fewer pends and rejections. The preferred electronic format is the Michigan Medicaid Interim Version of the National Electronic Data Interchange Transactions Set Health Care Claim: Institutional 837 (ASC X12N 837, version 4010). Up to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance effective date, MDCH will also accept the UB-92 EMC 5.0 format.

CLAIMS PROCESSING SYSTEM

All submitted claims are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically. The MDCH encourages claims to be sent electronically by file transfer or through the data exchange gateway. Electronic filing is more cost effective, more accurate, and payment is received quicker.

The CP System consists of several cycles:

- **The daily cycle** is the first set of computer programs to process all claims (paper and electronic). The daily cycle is run five to six times each week and performs a variety of editing (e.g., provider and beneficiary eligibility, procedure validity). All claims are reported out as pended, rejected, or tentatively approved.
- **The weekly cycle** is run once each week using the approved claims from the daily cycles that were run during the previous seven days. The weekly cycle edits claims against other paid claims and against certain reference files. Weekly editing includes duplicate claims, procedures with frequency limitations, etc. The provider's check (warrant) and remittance advice (RA) are also generated from this cycle. All claims are reported out as pended, rejected, or approved for payment.

REMITTANCE ADVICE

Once claims have been submitted and processed through the CP System, a remittance advice (RA) is sent to the provider and to the billing agent, if applicable. The RA section (Section 6) of this chapter contains additional information about the RA.

ADDITIONAL RESOURCE MATERIAL

Additional information needed to bill includes:

Medicaid Provider Manual: This manual contains Medicaid policy and special billing information. The manual is available at a nominal cost from the MDCH and can be ordered by calling (517) 335-5158.

HCPCS Codes: The Health Care Financing Administration Common Procedure Coding System (HCPCS) lists national codes and must be purchased annually. This publication is available from many sources, such as the AMA Press at 1-800-621-8335 or Medicode at 1-800-999-4600.

UB-92 Uniform Billing Manual: This manual may be purchased from the: Michigan Health and Hospital Association, Health Delivery & Finance Department, 6215 W. St. Joseph Hwy., Lansing, MI 48917-4852; phone (517) 323-3443.

International Classification of Diseases (ICD-9-CM): Diagnosis codes are required on your claims using the conventions detailed in this publication. This publication should be purchased annually. It may be requested from Medicode at 1-800-999-4600, or the AMA Press at 1-800-621-8335.

Bulletins: These intermittent publications supplement the Medicaid Home Health Manual. Bulletins are automatically mailed to enrolled providers and subscribers of the Medicaid Home Health Manual. Recent bulletins can be found on the MDCH website.

Numbered Letters: General program information or announcements are transmitted to providers via numbered letter.

Remittance Advice (RA) Messages: As needed, RA messages are sent with the remittance advices and give information about Medicaid policy and payment issues that affect the way you bill and receive payment.

Note: The MDCH website is www.mdch.state.mi.us. Click on *Medical Services Administration* and proceed to *Information for Medicaid Providers.*

HOW TO FILE CLAIMS

Claims may be submitted **electronically** or on **paper.** Electronic claim submission is the method preferred by the MDCH.

ELECTRONIC CLAIMS

Claims submitted electronically are entered directly into the Claims Processing System resulting in faster payments, and fewer pends and rejects. Claims can be submitted by file transfer or through the data exchange gateway. The preferred electronic format is the Michigan Medicaid Interim Version of the National Electronic Data Interchange Transactions Set Health Care Claim: Institutional 837 (ASC X12N 837, version 4010). Up to the HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance effective date, MDCH will also accept the UB-92 EMC 5.0 format.

Information on submission of electronic claims using the Michigan Medicaid Interim Institutional Version 4010 (ASC X12N 837) format is available on the DCH website at: www.mdch.state.mi.us, click on Medical Services Administration, Information for Medicaid Providers, Uniform Billing. For information on submission of the UB-92 electronic claim format, contact the Medicaid Automated Billing Coordinator (see next section.)

AUTHORIZED ELECTRONIC BILLING AGENT

Any biller who submits claims electronically to the MDCH must be an authorized electronic billing agent. A test process must be completed. The test consists of creating a test file of a minimum of 25 new claims and achieving a successful test run of that data through the MDCH Claims Processing System. Additional claims may be required if the testing shows a problem area. The test claims are not processed for payment. Any real claims for services rendered must be billed on paper until the provider has received approval to bill electronically.

Once the systems test has been passed, the billing agent will be issued a written authorization to participate as an electronic billing agent. In the event a provider decides to use a MDCH approved electronic billing agent, the provider must complete and submit to the MDCH a Billing Agent Authorization (DCH-1343) form. This form certifies that all the services the provider renders are in compliance with Medicaid guidelines. The MDCH will notify the provider when the DCH-1343 has been processed. At that time, the biller can begin billing electronically for the provider's services. If claims are submitted prior to receiving MDCH authorization, they will be rejected.

Any provider can submit claims electronically as long as a MDCH authorization is received, however, many providers find it easier to use an existing authorized billing agent. Most billing agents will accept claims electronically, in diskette, or on paper. The billing agent takes claim information gathered from all of its clients and formats it to the MDCH standards. The data are then sent to the MDCH for processing. Whether claims are submitted directly by the provider, or through another authorized billing agent, the provider will receive a remittance advice (RA). The billing agent will receive an RA that will contain information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents:

E-mail: AutomatedBilling@state.mi.us

Or write to:

Michigan Department of Community Health
Medicaid EDI Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

ELECTRONIC CLAIMS WITH ATTACHMENTS

Claims with extraneous attachments must be submitted on paper. **Condition Code 88** indicates documentation attached. On an electronic record, comments or additional information may be reported in the appropriate segments of the record.

PAPER CLAIMS

When submitting paper claims, use the UB-92 claim form. It must be a red-ink form with UB-92 HCFA-1450 in the lower left corner. Paper claims are scanned by an Optical Character Reader (OCR).

Claims may be prepared on a typewriter or on a computer. MDCH will not accept handwritten claims. The claims are optically scanned and converted to computer data before being processed. Print problems may cause misreads, delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn out ribbons. Mylar (plastic film) ribbon is preferred on dot matrix printers.

Questions and problems with the compatibility of equipment with MDCH scanners should be directed to the OCR Coordinator at:

Michigan Department of Community Health
Attn: OCR Coordinator - Operations
3423 N. MLK Jr. Blvd.
Lansing, MI 48909

OR

E-Mail Address: OCRCoordinator@state.mi.us

GUIDELINES TO COMPLETE PAPER CLAIM FORMS

The following guidelines are to be used in the preparation of paper claims to assure that information contained on the claims is correctly read by the scanning equipment. Failure to adhere to the guidelines may result in processing/payment delays or claims being returned unprocessed.

- Date of birth must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 03212002). All other dates must be six digits. Be sure the dates are within the appropriate boxes on the form.
- Use only black ink. Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12 point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. DO NOT squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use White-Out or correction tape.
- If a mistake is made, the provider should start over and prepare a "clean" claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, with no folding, in 9" x 12" or larger envelopes.
- Put a return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut edges of forms.
- Keep the file copy for your records.
- Separate claims by claim form type and mail each type separately.

PROVIDING DOCUMENTATION WITH PAPER CLAIM FORMS

When a claim attachment is required, it must be directly behind the claim it supports. Documentation must be on 8 ½ x 11" white paper and be one -sided. Do not submit two-sided material. Multiple claims cannot be submitted with one attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims that have no attachments in this envelope. Mail claims without attachments separately.

MAILING PAPER CLAIM FORMS

All paper claim forms and claim forms with attachments must be mailed to:

Michigan Department of Community Health|
Medical Services Administration
P.O. Box 30043
Lansing, MI 48909

UB-92 CLAIM COMPLETION INSTRUCTIONS

The home health agency submitting paper claims must bill on the UB-92 claim form using the instructions contained in the UB-92 Uniform Billing Manual with the following modifications.

INTERMITTENT NURSING VISITS/AIDE VISITS/THERAPIES

Billing Modifications:

Each Visit Must be Reported on a Separate Claim Line

Medicaid follows Medicare policy on the requirement that each home health agency visit (e.g., nursing, therapy) must be billed on an individual line. This policy includes two visits performed on the same day (i.e., two visits on the same day must be billed on individual lines).

15 - Minute Increment Reporting

Medicaid follows Medicare policy on the requirement that home health agencies must report home health visits in 15-minute increments. When billing on the UB-92 form, each home health visit reported in the "Revenue Code" field (FL 42) must have a corresponding 15-minute increment HCPCS code in the "HCPCS/Rates" field (FL 44) along with the number of 15-minute increments in the "Service Units" field (FL 46).

Reported visits are to be rounded to the nearest 15-minute increment. Rounding off to the nearest 15-minutes must be reported as follows:

Units	
1	1 minute to < 23 minutes
2	23 minutes to < 38 minutes
3	38 minutes to <53 minutes
4	53 minutes to <68 minutes
5	68 minutes to <83 minutes
6	83 minutes to <98 minutes
7	98 minutes to < 113 minutes
8	113 minutes to < 128 minutes

If services continue for longer periods of time, the home health agency would follow the above pattern.

Time of Service Visit: The timing of the visit begins at the beneficiary's home when services actively begin and end when services are completed. The time counted must be the time spent actively treating the beneficiary.

For example:

- If a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than 3 minutes), then the time the beneficiary spends on the telephone and not engaged in treatment does not count in the amount of service.
- The home health aide completed bathing and transferring the beneficiary into a chair, and now begins to wash the kitchen dishes before leaving. Washing the dishes is considered incidental and does not meet the definition of a home health aide service. Therefore, the time to perform this activity would not be included in the 15-minute incremental reporting to Medicaid.

Other non-treatment related interruptions would follow the same principle. If the beneficiary is late returning home from a doctor's appointment, the waiting time of the home health agency personnel also cannot be counted as treatment time.

However, if the professional spends time with family or other caretakers in the home teaching them to care for the beneficiary, this activity **is** counted as treatment time. If the nurse calls the physician to report on the beneficiary's condition while in the beneficiary's home, this can also be counted as treatment time.

NOTE: If beneficiary assessment activities for completion of the OASIS data set are a part of an otherwise covered and billable visit, time spent in beneficiary assessment may be included in the total count of 15-minute increments. The completion of the assessment activities must be incorporated into a visit providing otherwise necessary home health care to the beneficiary. A separate visit made only to collect information for the OASIS assessment but not to provide other covered home health services would not be billable.

POSTPARTUM/NEWBORN FOLLOW-UP NURSE VISIT

Medicaid allows one (1) *initia*l postpartum and one (1) *initial* newborn visit per pregnancy. The initial postpartum visit must be billed using the mother's Medicaid ID#. The initial newborn visit must be billed using the newborn's Medicaid ID#.

Medicaid allows one (1) *subsequent* visit to the mother and newborn. This subsequent visit may be billed under either the mother's ID# or newborn's ID#, based on which beneficiary the nurse spent the majority of the time.

BLOOD LEAD POISONING NURSING ASSESSMENT/INVESTIGATION VISITS

Coverage is limited up to two (2) visits per episode per child diagnosed with blood lead poisoning. If more than one child in the home has blood lead poisoning, nurse education visits may be billed for each child. As with other home health services, this service must be ordered by the beneficiary's physician. When billing, the agency must use Procedure Code Z6220 and use the child's Medicaid ID Number.

REPLACEMENT CLAIMS

Replacement claims (adjustments) are submitted when all or a portion of the claim was paid incorrectly or a third-party payment was received after DCH made payment. When replacement claims are received, DCH deletes the original claim and replaces it with the information from the replacement claim. It is very important to include **all** service lines on the replacement claim, whether they were paid incorrectly or not. All money paid on the first claim will be taken back and payment will be based on information reported on the replacement claim only. Examples of reasons a claim may need to be replaced:

- to return an overpayment.
- to correct information submitted on the original claim.
- to report payment from another source after DCH paid the claim.
- to correct information that the scanner may have misread.

If the provider needs to do a replacement of a previously paid claim, a **7** must be indicated **as the third digit "frequency" (xx7**) in the Type of Bill (Form Locator 4)**.**

The provider must enter in Form Locator 37 the 10-digit Claim Reference Number of the last approved claim or adjustment being replaced.

The provider must enter in Form Locator 84 the reason for the replacement.

See Medicaid claim example in the UB-92 Uniform Billing Manual.

VOID/CANCEL OF A PRIOR CLAIM

If a claim was paid under the wrong provider or beneficiary ID Number, the provider must void/cancel that claim. To void/cancel the claim, the provider must indicate in the Type of Bill (Form Locator 4) an **8 (xx8) as the third digit "frequency."** The 8 indicates that the bill is an exact duplicate of a previously paid claim, and the provider wants to void/cancel that claim. The provider must enter in Form Locator 37 the 10-digit Claim Reference Number of the last approved claim or adjustment being cancelled **and** enter in Form Locator 84 the reason for the void/cancel. **Note:** A void/cancel claim must be completed exactly as the original claim.

A new claim may then be submitted using the correct provider or beneficiary ID number.

See Medicaid claim example in the UB-92 Uniform Billing Manual.

REFUND OF PAYMENT

Providers may refund payments to the MDCH when the entire amount paid for a claim needs to be returned due to overpayment, either from a third-party resource or due to an error. A copy of the RA, with a check made out to the "State of Michigan" in the amount of the refund, should be sent to:

Michigan Department of Community Health
Cashier's Unit
P. O. Box 30223
Lansing, MI 48909

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GENERAL BILLING INFORMATION FOR THIRD-PARTY COVERAGE

Third Party Liability (TPL): Payment resources available from both private and public insurance and other liable third parties that can be applied toward a beneficiary's health care expenses.

Third Party Payer: Any individual, entity, or program that is or may be liable to pay all or part of health care costs incurred by a beneficiary. This includes Medicare, an insurance company, commercial health maintenance organization (HMO), preferred provider organization (PPO), Champus, Workers' Compensation and automobile insurance.

Private health care coverage and accident insurance, including coverage held by or on behalf of a MDCH beneficiary, is considered primary and must be billed according to the rules of the specific plan. The MDCH will not pay for services that would have been covered by the private payer if applicable rules of that private plan had been followed. A beneficiary with more than one level of private coverage must receive care at the highest level available. Providers are expected to take full advantage of the highest other insurance coverage from any third party resource (accept assignment, enrollment, participation).

Insurance carrier billing information is contained in the Carrier ID Listing in the Other Insurance Appendix of this manual.

If the provider does not participate with the commercial insurance carrier, the provider is expected to refer the beneficiary to a participating provider with the commercial coverage. Beneficiaries may obtain a list of participating providers from the insurance carrier. If a participating provider is not available, the provider should contact the TPL area for assistance. Phone 1-800-292-2550 or e-mail TPL@state.mi.us.

The Medicaid ID Card does contain Medicare and other insurance information, but the most current coverage information made known to MDCH is available from the Department's Eligibility Verification Contractor: 1-888-696-3510. Because coverage points change, it is still the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to provision of the service.

Providers must always identify third-party resources and total third-party payments when submitting a claim to the MDCH.

MEDICARE

Home health agencies are reminded that federal regulations require Medicaid providers to bill all available third-party resources, including Medicare, prior to billing Medicaid. Upon a decision from Medicare, home health agencies are further reminded of the following.

Medicare's payment under its prospective payment system is for each 60-day episode of care for each beneficiary. If a beneficiary qualifies for care after the end of the first episode, a second episode can begin. There are no limits to the number of episodes a beneficiary can have as long as he/she continues to qualify for home health care (e.g., beneficiary is confined to the home, services are reasonable and necessary to the treatment of an illness or injury). The prospective payment rate for the episode of care includes all nursing and therapy services, routine and non-routine medical supplies, and home health aide and medical social services.

If Medicare covers the service, Medicare pays 100% for allowable services. Therefore, an agency should never bill Medicaid for co-insurance or deductible amounts.

Home health agencies must accept Medicare's prospective payment as payment in full. The home health agency must not seek nor accept additional or supplemental payment from the Medicaid beneficiary, his/her family, or representative in addition to the amount paid by Medicare.

Home health agencies are required to provide Medicare beneficiaries with a proper Advance Beneficiary Notice (ABN) if it refuses to initiate care, or reduces or terminates service because it believes Medicare will not cover the services that a physician has ordered. The home health agency must also provide the beneficiary with information about appeal rights. The home health agency is also required to submit demand bills to Regional Home Health Intermediaries (RHHIs) when requested to do so by the beneficiary because the beneficiary believes the services are covered by Medicare. Until the home health agency is in receipt of a Medicare denial notice, Medicaid cannot be billed.

OTHER INSURANCE

If a Medicaid beneficiary has insurance coverage via a traditional insurance plan, or is enrolled in a commercial health maintenance organization (HMO) or other managed care plan, the rules for coverage by the commercial plan must be followed. The beneficiary must seek care from network providers and authorization or a referral must be obtained as necessary. If the coverage rules of the commercial plan are not followed, the MDCH is not liable for payment of services denied by the plan for these reasons. Medicaid will only pay for services excluded from plan coverage if they are covered Medicaid services.

Medicaid will pay fixed co-pays, co-insurance and deductibles up to the allowable screen as long as the rules of the commercial coverage plan (point of service, PPO, etc.) are followed. The beneficiary must use the highest level of benefits available to them under the policy. For example, Medicaid will not pay the point of service sanction amount for the beneficiary electing to go out of network.

Providers may enter into agreements with third-party payers to accept payment for less than their usual and customary charges. These arrangements are often called "Preferred Provider" or "Participating Provider Agreements," and are considered payment in full for services rendered. Since the insured has no further liability to pay, the MDCH has no liability. The MDCH may only be billed if the third-party payer has determined the insured/beneficiary has a legal obligation to pay.

If payments are made by a commercial insurance, the amount paid, whether it is paid to the provider or the policyholder of the insurance, must be entered in Form Locator 54. If the provider does not accept direct payment from the other insurance, or the other insurance company does not allow direct payment to the provider, it is the provider's responsibility to obtain the money from the policyholder. It is acceptable to bill the policyholder in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the commercial coverage.

If there is court-ordered support and the provider is having trouble collecting other insurance payments sent directly to the absent parent, the provider should contact the TPL area for assistance. Phone 1-800-292-2550 or e-mail TPL@state.mi.us.

SPEND-DOWN LIABILITY

If a patient is a "spend-down" beneficiary, the spend-down amount must be incurred before the beneficiary is eligible for Medicaid. The provider should bill the patient for the spend-down charges until the maximum is reached. The beneficiary does not have to pay these charges before becoming Medicaid eligible, but must incur the costs.

If the spend-down maximum is reached in the middle of a service, and part of the charge is the patient's responsibility and part is Medicaid's responsibility, report the full charge for the service in Form Locator 47 of the service line. Report the spend-down as Value Code 66 and the amount of the patient's liability in Form Locators 39-41, as appropriate.

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GENERAL INFORMATION

The MDCH establishes a payment amount for all procedure codes in the claims processing system. All other resources, including Medicare, must be billed prior to billing Medicaid or Children's Special Health Care Services (CSHCS). When a payment has been made by another resource, Medicaid payment is determined by comparing its normal payment (or the provider's charge, whichever is less) to the amount paid by the other resource.

The remittance advice (RA) shows what action was taken on the provider's claim. It shows the claims processed for payment, new claims that pended, and claims that were rejected. The codes next to each service line explain the action taken. The definitions to the codes are listed in the Explanation Code Appendix of this manual.

The MDCH processes claims and issues checks (warrants) every week unless special provisions for payments are included in your enrollment agreement. An RA is sent with each check to explain the payment made for each claim. If no payment is due, but claims have pended or rejected, an RA will also be issued. If claims are not submitted for the current pay cycle and no action is taken on previously pended claims, an RA is not printed.

Note: If the total amount approved for claims on any one RA is less than $5.00, a check is not issued for that pay cycle. Instead, a balance is held until approved claims accumulate to an amount equal to or more than $5.00. Twice a year (usually in June and December) all amounts of less than $5.00 are paid.

If a claim does not appear on an RA within 30 days of submission, a new claim should be submitted. The provider should verify that the provider ID# and beneficiary ID# are correct.

REMITTANCE ADVICE MESSAGES

A message may be printed on the next to the last page of the RA or it may be inserted as a flyer. The messages give current information about policy and payment issues. For example, MDCH sends messages to:

- clarify a billing instruction,
- explain problems in the payment system,
- remind providers of a change in programs,
- announce a delay in payment, or
- notify providers of billing seminars.

REMITTANCE ADVICE (RA) HEADER

The RA header contains the following information:

- Provider ID No. and Provider Type: This is the provider ID# from the provider's claim. The first two digits of the Provi der ID# appear in the Provider Type box and the last seven digits appear in the Provider No. box.
- Provider Name: This is from the MDCH provider enrollment record for the provider ID# submitted on the claim.
- Pay Cycle: This is the pay cycle number for this RA.
- Pay Date: This is the date the RA is issued.
- Page No.: Pages of the RA are numbered consecutively.
- Federal Employer ID Number or Social Security Number: This is in small print in the upper right corner and is unlabeled. The number on the provider's claim must match the billing provider ID number on file with the MDCH and it must be a valid number with the Michigan Department of Treasury. MDCH cannot issue a check if there is a discrepancy between the number on file with the MDCH or the Michigan Department of Treasury.

  Note: If any of the information is incorrect, the provider must contact the Provider Enrollment Unit at (517) 335-5492 to make changes.

REMITTANCE ADVICE (RA) CLAIM INFORMATION

Claims appear on the RA in alphabetical order by the beneficiary's last name. If there is more than one claim for a beneficiary, they appear in Claim Reference Number (CRN) order under the beneficiary's name.

Claim Header

- Patient ID Number: Prints the beneficiary's Medicaid ID number that the provider entered on the claim.
- Patient Name: Prints the name associated with the beneficiary's ID from the Medicaid eligibility file. If the beneficiary's ID number is not entered on the claim or is not valid, zeros are printed and the claim is rejected. These claims print first on the RA.

Service Line Information

- Prov. Ref. No.: The left-most 14 characters of the patient account number the provider entered on the claim are printed here.
- Claim Reference Number (CRN): A 10-digit CRN is assigned to each claim. If the claim has more than one service line, the same CRN is assigned to each line. The first four digits of the CRN are the Julian Date the claim was received by MDCH. The fifth through tenth digits are the sequential claim number assigned by the MDCH.

  For example: In CRN 2223112345, 2 is the year 2002, 223 is the Julian (August 11) day of the year, and 112345 is the sequence number. The combination of Julian date and sequence makes a unique number that is assigned to each claim. When asking about a particular claim, the provider must refer to the CRN and Pay Date.

The 10-digit CRN is followed by a two-character input ID (2223223445**-XX).** If a service bureau submitted the claim, this will be the service bureau ID. If the provider submitted a paper claim, this will be a scanner identifier.

- **Line No.:** This identifies the line number where the information was entered on the claim.
- **Invoice Date:** This identifies the date the provider entered on the claim or, if left blank, the date the claim was processed by the system.
- **Service Date:** This identifies the service date entered on the claim line.
- **Diagnosis Code:** This identifies the principal diagnosis entered on the claim.
- **Procedure Code:** This identifies the revenue code entered on the service line.
- **Qty:** This identifies the quantity entered on the service line. If the MDCH changed your quantity, an informational edit will appear in the explanation code column.
- **Amount Billed:** This identifies the charge entered on the service line.
- **Amount Approved:** This identifies the amount Medicaid approved for the service line. Pended and rejected service lines show the amount approved as zero (.00). Zero also prints when no payment is due from Medicaid. For example, when other resources made a payment greater than Medicaid's usual payment.
- **Source/Status:** This identifies the source of funding for paid lines and shows the status of unpaid lines. One claim may have several source codes. The status codes for paid lines are:

MA	Medicaid
SMP	State Medical Program
CC	Children's Special Health Care Services
CC/MA	Children's Special Health Care Services and Medicaid
CIR	Cuban/Indochinese Refugee or Repatriate
CO-DED	Medicare patient

The status codes for unpaid lines are:

REJ	The service line is rejected.
PEND	The service line is pending and is being manually reviewed.

Note: If one service line on the claim is pending, then all service lines have a PEND status.

- **Explanation Codes:** Explanation Codes indicate the reason a service line was rejected or pended. They also give information about service lines and may point out potential problems. A complete listing of explanation codes and the code indicators are found in the Explanation Code Appendix.
- **Invoice Total:** Totals for the Amount Billed and the Amount Approved print here.
- **Insurance Information:** If Medicaid beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g. vision, medical) print below the last service line information.
- **History Editing:** Certain edits compare the information on the claim to previously paid claims. In some cases, information about the previous claim will print on the RA. This information prints directly under the service line to which it relates. The Explanation Code Appendix contains information on history edits.

- **Page Total:** This is the total Amount Approved for all service lines on the page. If a claim has service lines appearing on two RA pages, the page total will include only the paid lines printed on each RA page.

Note: Amounts for pended service lines and rejected service lines are not included on the page total.

GROSS ADJUSTMENTS

Gross adjustments are initiated by MDCH. A gross adjustment may pertain to one or more claims.

MDCH notifies providers, in writing, when an adjustment will be made. The provider should receive the notification before the gross adjustment appears on the remittance advice (RA).

TYPES OF GROSS ADJUSTMENTS

One of the following adjustment codes prints in the Amount Billed column:

- GACR is a Gross Adjustment Credit. This appears when the provider owes MDCH money. The gross adjustment amount is subtracted from the provider's approved claims on the current payroll.
- GADB is a Gross Adjustment Debit. This appears when MDCH owes the provider money. The gross adjustment amount is added to the provider's approved claims on the current payroll.
- GAIR is a Gross Adjustment Internal Revenue. This appears when the provider has returned money to the MDCH by check instead of submitting a replacement claim. It is subtracted from the Year-to-Date (YTD) Payment Total shown on the summary page of the RA.

REMITTANCE ADVICE SUMMARY PAGE

The Summary Page is the last page of the RA and gives totals on all claims for the current payroll and year-to-date totals from previous payrolls.

This Payroll Status: This indicates the total number of claims and the dollar amount for the current payroll. This includes new claims plus your pended claims from previous payrolls that were paid, rejected, or pended on the current payroll.

- **Approved:** This is the number of claims from this payroll with a payment approved for every service line. The dollar amount is the total that the MDCH approved for payment.
- **Edit 504 Pends:** This is the number of claim forms with dates of service that are too old for immediate processing. The dollar amount is the amount the provider billed.
- **All Other Pends:** This is the number of claims from this payroll that are pending. The dollar amount is the total charges billed.
- **Rejected:** This is the number of claim lines from this payroll that were rejected. The dollar amount is the total charges billed.
- **App'd/Rejected:** This is the number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total approved and the amount next to Rejected Claim Lines is the total charge billed.

- **Total Pends in System:** This is the total number of new and unresolved pended claims in the system and total charges.

- **Previous YTD (Year-to-Date) Payment Total:** This is the total amount paid to the provider for the calendar year before any additions or subtractions for this payroll.

- **Payment Amount Approved This Payroll:** This is the total dollar amount approved for this payroll.

- **Actual Payment Due This Payroll To Provider:** This amount is the Payment Amount Approved plus any balance due to the provider and minus any balance owed by the provider to MDCH.

- **Payment Made This Payroll:** This is the amount of the check issued for this payroll.

- **New YTD Payment Total This Payroll:** This is the total payment for the calendar year including payments made on this payroll.

- **Balanced Owed or Balance Due:** One or more of the following prints if the provider has a balance owed or a balance due.

    - **Balance Due to Provider by MDCH:** This appears if the payment amount approved is less than $5.00 or a State account is exhausted.
    - **Balance Owed by Provider to MDCH:** This appears when money is owed to MDCH, but the provider does not have enough approved claims from a particular State account (e.g., CC or SMP) to deduct what is owed.
    - **Previous Payment Approved, Not Paid:** This appears if a balance is due from MDCH on the previous payroll.
    - **Previous Payment Owed by Provider to MDCH:** This prints when a balance is due from the provider on a previous payroll.

- **Pay Source Summary:** This identifies the dollar amounts paid to the provider from the designated State accounts.

PENDED AND REJECTED CLAIMS

When claims are initially processed, the Source Status column on the RA identifies which service lines have been paid, rejected or pended. The RA explanation code column lists edits which apply to each service line.

Rejections: If a service line is rejected, an explanation code or codes followed by an R will print in the Explanation Code column of the RA (e.g. 092R). The provider should review the definitions of the codes found in the Explanation Code Appendix to determine the reason for the rejection.

Pends: If any claim line pends for manual review, PEND prints in the Source Status column for all the service lines on the claim. An explanation code or codes, followed by a P (e.g. 936P), will print in the Explanation Code column of the RA. These pended claims will not print again on the RA until:

- the claim is paid or rejected, or
- is pended again for another reason, or
- has pended for 60 days or longer.

Note: After a claim initially pends, it may pend again for a different reason. In that case, a symbol (#) will print in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.

If the MDCH determines that the claim can continue through the claims processing system, the edit will appear with a * (e.g. 936*) on your RA. If the MDCH determines that the service line should be rejected for the reason specified by the pending edit, an additional edit will be added to the service line (e.g. 727R, 936P) and the Source Status code on the line will say REJ.

When a claim is pended, the provider must wait until it is paid or rejected before submitting another claim for the same service.

JULIAN CALENDAR

Day 'Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

For leap year, one day must be added to number of days after February 28. The next three leap years are 2004, 2008 and 2012.

Example: claim reference # 1351203770-59
1 = year of 2001
351 = Julian date for December 17
203770 = consecutive # of invoice
59 = internal processing

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The MDCH has numerous resources to assist you with billing services to Medicaid.

Michigan Department of Community Health Website: Go to: www.mdch.state.mi.us. Click on *Medical Services Administration* where you will find Medicaid-related information including a listing of health plans, a sanctioned provider list, fee screens, procedure code listings, policy bulletins and other relevant Medicaid information.

Electronic Billing Resources: For information on submission of electronic claims using the Michigan Medicaid Interim Institutional Version 4010 (ASC X12N 837) format, see the User's Guide, transaction set, and envelope information documents on the MDCH website at: www.mdch.state.mi.us, click on Medical Services Administration, Information for Medicaid Providers, Uniform Billing.

Use the following addresses to submit your questions on electronic billing, request forms to become an authorized billing agent, or to schedule electronic testing of claims. Be sure to include your name, phone number and address with all inquiries.

E-mail: AutomatedBilling@state.mi.us

Or write to: Michigan Department of Community Health
Medicaid EDI Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

Provider Inquiry: Direct questions on program coverages, claim completion instructions, and information printed on the remittance advice (RA) to:

1-800-292-2550

Review the information in the manual pertaining to the policy or procedure before you call. Have your Medicaid provider ID number, the claim information and the RA (if applicable) when you call. Ask for the telephone representative's name so you can speak to the same person if a follow-up call is necessary.

Written Requests: You may e-mail questions or send them hard copy by mail. Include your name, phone number, provider ID #, beneficiary name and ID#, CRN and pay cycle as appropriate. Include a clear, concise statement of the problem or question.

E-mail: ProviderSupport@state.mi.us

Or write to: Research and Analysis
Medical Services Administration
P. O. Box 30479
Lansing, MI 48909

Provider Training Sessions: (517) 335-5149. MDCH staff conducts provider-training sessions throughout the state targeted to specific provider groups. Receive information on schedules, training session content, and reservations.

TPL (Third Party Liability) Help: Staff resolves calls regarding other insurance additions and terminations, billing problems involving other insurance, and disenrollment from health plans when there is commercial HMO coverage.

☎ 1-800-292-2550

E-mail: TPL@state.mi.us

Provider Enrollment Help: ☎ (517) 335-5492. Requests for enrollment applications or questions about current enrollment, and all change of ownership, change of address, or change in federal tax employer ID numbers or social security numbers should be directed here.

Manuals: ☎ (517) 335-5158 for information on ordering provider manuals. This manual and other Medicaid publications are available at a nominal cost from MDCH.

Miscellaneous Transactions Unit (MTU): ☎ (517) 335-5477 to get information on submitting out-of-state or non-enrolled provider claims.

Eligibility Verification Contractor: ☎ 1-888-696-3510 to determine a beneficiary's eligibility status, health plan enrollment status, and other insurance coverage.

When billing on the UB-92 claim form, the home health agency must use the following codes. The HCPCS codes are located in the Health Care Financing Administration Common Procedure Coding System manual. The Revenue Codes are located in the UB Manual.

HOME HEALTH AGENCY VISITS

DESCRIPTION	REVENUE CODES	HCPCS/LOCAL CODES
Nursing Visit	550, 551, or 552 as appropriate	G0154 (HCPCS)
Blood Lead Poisoning Nurse Education Visit	550, 551, or 552 as appropriate	Z6220 (Medicaid Local Code)
Home Health Aide Visit	570, 571, or 572 as appropriate	G0156 (HCPCS)
Physical Therapy Visit	420, 421, 422, or 424 as appropriate	G0151 (HCPCS)
Occupational Therapy Visit - Only covered for children under age 21 through the Children's Special Health Care Services (CSHCS) Program.	430, 431, 432, or 434 as appropriate	G0152 (HCPCS)

MEDICAL SUPPLIES ITEMS

HCPCS Code	Description	Quantity Per Month
Miscellaneous Supplies		
A4244	Alcohol or peroxide, per pint	8
A4246	Betadine or PhisoHex solution, per pint	8
Incontinence Appliances and Care Supplies		
A4310	Insertion tray without drainage bag and without catheter (accessories only)	2
A4311	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating	2
A4312	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone	2
A4313	Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	2
A4314	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating	2
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone	2
A4316	Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation	2
A4320	Irrigation tray with bulb or piston syringe	30
A4322	Irrigation syringe, bulb or piston, each	30

MEDICAL SUPPLIES ITEMS

HCPCS Code	Description	Quantity Per Month
A4324	Male external catheter, with adhesive coating, each	96
A4325	Male external catheter, with adhesive strip, each	96
A4326	Male external catheter specialty type (e.g., inflatable, faceplate, etc.) each	30
A4327	Female external urinary collection device; metal cup, each	1
A4328	Female external urinary collection device; pouch, each	10
A4331	Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each	4
A4333	Urinary catheter anchoring device, adhesive skin attachment, each	4
A4334	Urinary catheter anchoring device, leg strap, each	6 per 3 months
A4338	Indwelling catheter; Foley type, two-way latex with coating, each	2
A4344	Indwelling catheter, Foley type, two-way, all silicone, each	5
A4346	Indwelling catheter; Foley type, three-way for continuous irrigation, each	6
A4351	Intermittent urinary catheter; straight tip, each	150
A4352	Intermittent urinary catheter; curved tip, each	150
External Urinary Supplies		
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each	3
A4358	Urinary leg bag; vinyl, with or without tube, each	10
Additional Miscellaneous Supplies		
A4454	Tape, all types, all sizes	12
A4554	Disposable underpads, all sizes (e.g., Chux's)	180
A4927	Gloves, sterile or nonsterile, per pair	200
Supplies for Oxygen and Related Respiratory Equipment		
A4629	Tracheostomy care kit for established tracheostomy	30
Dressings		
A6196	Alginate dressing, wound cover, pad size 16 sq. in. or less, each dressing	30
A6197	Alginate dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	30
A6198	Alginate dressing, wound cover, pad size more then 48 sq. in., each dressing	30

MEDICAL SUPPLIES ITEMS

HCPCS Code	Description	Quantity Per Month
A6199	Alginate dressing, wound filler, per 6 inches	30
A6203	Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing	30
A6204	Composite dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., , with any size adhesive border, each dressing	30
A6205	Composite dressing, pad size more than 48 sq. in. with any size adhesive border, each dressing	30
A6206	Contact layer, 16 sq. in. or less, each dressing	30
A6207	Contact layer, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	30
A6208	Contact layer, more than 48 sq. in., each dressing	30
A6209	Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	30
A6210	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in. without adhesive border, each dressing	30
A6211	Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	30
A6212	Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	30
A6213	Foam dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	30
A6214	Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	30
A6215	Foam dressing, wound filler, per gram	240
A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	200
A6217	Gauze, non-impregnated, non-sterile, more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	200
A6218	Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing	200
A6219	Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing	200
A6220	Gauze, non-impregnated, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	200
A6221	Gauze, non-impregnated, pad size more than 48 sq. in., with any size adhesive border, each dressing	200
A6222	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing	200
A6223	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	200
A6224	Gauze, impregnated with other than water, normal saline, or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing	200

MEDICAL SUPPLIES ITEMS

HCPCS Code	Description	Quantity Per Month
A6234	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	30
A6235	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	30
A6236	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	30
A6237	Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	30
A6238	Hydrocolloid dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	30
A6239	Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	30
A6240	Hydrocolloid dressing, wound filler, paste, per fluid ounce	10
A6241	Hydrocolloid dressing, wound filler, dry form, per gram	240
A6242	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	30
A6243	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	30
A6244	Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	30
A6245	Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	30
A6246	Hydrogel dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	30
A6247	Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	30
A6248	Hydrogel dressing, wound filler, gel, per fluid ounce	10
A6251	Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing	30
A6252	Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	30
A6253	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing	30
A6254	Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing	30
A6255	Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing	30
A6256	Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing	30
A6257	Transparent film, 16 sq. in. or less, each dressing	30
A6258	Transparent film, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing	30
A6259	Transparent film, more than 48 sq. in., each dressing	30

MEDICAL SUPPLIES ITEMS

HCPCS Code	Description	Quantity Per Month
A6263	Gauze, elastic, non-sterile, all types, per linear yard	180
A6264	Gauze, non-elastic, non-sterile, per linear yard	180
A6266	Gauze, impregnated, other than water or normal saline, any width, per linear yard	30
A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing	200
A6403	Gauze, non-impregnated, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing	200
A6404	Gauze, non-impregnated, sterile, pad size more than 48 sq. in. without adhesive border, each dressing	200
A6405	Gauze, elastic, sterile, all types, per linear yard	180
A6406	Gauze, non-elastic, sterile, all types, per linear yard	180