MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Medical Suppliers 01-07

Issued: November 1, 2001

Subject: Uniform Billing Changes

Effective: February 1, 2002

Programs Affected: Medicaid, Children's Special Health Care Services and State Medical Program

Effective February 1, 2002, all claims submitted by Orthotists, Prosthetists, Medical Suppliers, Shoe Store Vendors, and Oxygen Suppliers must use the HCFA 1500 claim form or the National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 ASCX12N version 3051 or Michigan Medicaid Interim version 4010 electronic claim format. These billing standards are consistent with other major payers and are a step toward Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance for transactions and code sets. **This change applies to all claims submitted on and after February 1, 2002, regardless of the date of service.**

This bulletin contains information about specific changes being implemented due to the transition of the new claim formats. **Detailed claim completion and submission instructions are provided in bulletin MSA 01-23, Uniform Billing, Revisions for Chapter IV (Billing & Reimbursement).** Copies of all draft and final policy bulletins, the electronic claim transaction set, and other information related to changes being made are available on the Department's website at www.mdch.state.mi.us, click on Medical Services Administration, Information for Medicaid Providers.

The following changes will be implemented **February 1, 2002**:

- **Claims for ancillary services** will be submitted on either the HCFA 1500 paper claim or the National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051 or Michigan Medicaid Interim version 4010) electronic format.

- **Procedure codes** – Many of the Michigan Medicaid local procedure codes are being replaced with the national standard (Health Care Financing Administration) Common Procedure Coding System (HCPCS). The remaining Michigan local codes will be phased out prior to HIPAA implementation, October 16, 2002. Revisions to procedure codes will be available as part of a Medicaid Ancillary Database that will be provided on the MDCH website. The database will include all Medicaid covered ancillary services. The actual data will include the HCPCS procedure code, short description, designated modifiers, quantity limits, payment indicator, prior authorization (PA) indicator, fee screen, and

whether the items may be billed as a "right" or "left" procedure. **Providers must report the procedure code that was "in effect" on the date the service was rendered**. If an item was prior authorized with one of the former procedure codes, the appropriate new code should be billed to Medicaid instead if it was "in effect" at the time the service was rendered.

- **Modifiers** utilized for ancillary services must be HCPCS (as updated annually) or the remaining Michigan Medicaid local codes as described later in this bulletin. **Providers must report the modifier or type of service code that was "in effect" on the date the service was rendered.**

- **Coordination of Benefits (COB)** is to be reported in lieu of the other insurance codes. The other insurance payment or spend down liability amount should be listed in Field 24 K. An Explanation of Benefits (EOB) must be submitted with the claim if the other insurance made payment or applied charges to the deductible.

- **Diagnosis Coding,** using the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM), must be reported to the most specific code available that identifies the reason each item was provided. Up to four ICD-9-CM diagnosis codes can be entered per claim level on the paper form and up to eight diagnosis codes can be entered in the electronic format. Each service line must be linked to a diagnosis code.

- **Date of Service (DOS)** is to be reported using eight digits in the two fields, "From" and "To" dates, on the HCFA 1500 and the electronic format. The same DOS should be used in both fields on each service line. **For medical supplies**, the date supplied is the date of service. For the Diaper and Incontinent Supplier Contract, the date the order is transmitted to the contractor's fulfillment house shall be the date of service. **For both custom and non-custom durable medical equipment (DME)** and **prosthetics and orthotics (P & O**), use the date of delivery as the date of service. If a custom-made DME item or a prosthetic/orthotic device is ordered prior to either a "loss" or "change" of beneficiary eligibility, the provider must use the order date as the date of service. If the beneficiary's death occurs during a DME rental month after payment has been made, the prorating of actual days used is no longer required.

- **Days or Units** are to be reported in Box 24G of the HCFA 1500 format. For services that are reported as a daily rate, the number should represent the days the item or supply was provided. For services reported by amount used, the number should represent the appropriate quantity. The quantity field of the HCFA 1500 format will accommodate up to three digits.

- **Emergent Condition Code Values** replace the former emergency codes. "Y" = emergency and "N" = not an emergency.

- **Federal Tax ID Number or Social Security Number** is required in Field 25 on the HCFA 1500 paper billing form and the comparable field in the electronic billing format.

- **Place of Service Code** must be reported for each item by entering the appropriate two digit "Place of Service Code" from the list of HCFA approved definitions for place of service. Items are to be billed in the setting they are used. The acceptable place of service codes allowed for Medicaid purposes as they relate to these items are as follows:
  - **12** – Home
  - **31** – Skilled nursing facility
  - **32** – Nursing facility
  - **33** - Custodial care facility

- **Provider Type and ID Number** must be reported as a one "9 digit" value in Field 33 on the paper HCFA 1500 format. Please list the "2 digit" type code first and the "7 digit" provider ID number second to comprise the new "9 digit" value. All "9 digit" values must be reported in this order.

Payment Policy

- **Fee Schedule** applies to the established fee screen for each item and is available on the MDCH website at www.mdch.state.mi.us/msa/mdch_msa/medicaid/data.htm, click on Medicaid Fee Screens for Special Services. Specific HCPCS code and applicable modifier determines the fee screen. For "Not Otherwise Classified" codes and all other codes with no standard fee screen, the allowable Medicaid fee screen amount is determined through the prior authorization process.

- **Modifiers** are utilized under certain circumstances to more accurately represent the service or item provided. There are three levels of modifiers: Level I being those included in CPT and updated annually by the American Medical Association; Level II (HCPCS) recognized nationally and updated annually by CMS (Centers for Medicare and Medicaid Services); and Level III, those assigned for use within an individual state. (Remaining Michigan Medicaid local modifiers will be accepted until October 16, 2002 unless notified otherwise). Providers will utilize HCPCS and Michigan Medicaid local modifiers and should refer to **bulletin MSA 01-23, Uniform Billing, Revisions for Chapter IV (Billing & Reimbursement)** for detailed information regarding modifiers and their use. The "Type of Service" code will no longer be used (i.e., G, J or T). **Providers must report the new modifiers for any date of service on and after February 1, 2002.** If a procedure code was prior authorized with one of the former "type of service" codes, the appropriate new modifier should be billed to Medicaid instead if it was "in effect" at the time the service was rendered.

  - **Modifiers to be used for "Purchase" of an item**:
    For **medical supplies**, leave Box 24D blank unless one of the remaining Michigan Medicaid local modifiers is necessary to designate a specific size.

    For **DME items**, the new equipment modifier (NU) or the used equipment modifier (UE) should be reported for all applicable procedure codes. Michigan Medicaid local modifiers that designate a specific size apply to specific "Y" procedure codes only.

For **orthotic and prosthetic items**, the "LT" and "RT" modifiers are required to designate either the left or right side of the body if applicable. To report bilateral items provided on the same date of service, list each item on separate service lines and use a quantity of "1". The frequency limits are based on the individual item being replaced. To determine whether a procedure code requires the "LT" or "RT" to be reported, refer to the Medicaid Ancillary Database which will be provided on the MDCH website.

- **Modifier to be used for "Rental" of an item:**
  For the rental of **DME items**, the "RR" rental modifier is required.

- **Modifier to be used for "Replacement or Repair" of an item:**
  For **DME items**, the "RP" modifier should be reported and includes the cost of the component and the labor associated with the removal, replacement and finishing of that component. For unusual situations, when no existing HCPCS code is appropriate, report code E1340 (for the labor charge) and code E1399 (for the replacement part). For wheelchairs, K0108 may be used in place of E1399. Prior authorization is required.

  For **prosthetics/orthotics**, use the "RP" modifier to report the repair or replacement of an item which includes the cost of the component and the labor associated with the removal, replacement and finishing of that component. For unusual situations, when no existing HCPCS code is appropriate, report the labor charge by using L7520 (for prosthetics) or code L4205 (for orthotics). For minor materials used in repairing the item, report code L7510 (for prosthetics) or code L4210 (for orthotics). Prior authorization is required.

- **Prior Authorization (PA) Process**

The PA number is reported in Box 23 and will continue to be a "9 digit" number.

Medicare:

PA is not necessary if the following situations apply:

- The beneficiary is Medicare eligible
- Medicare covers the service
- Medicaid's only liability is the co-insurance and/or deductible amount.

PA will be necessary if:

- Medicare identifies a service as an excluded benefit but the service requires PA based on Medicaid's guidelines.

Other Insurance Coverage:

PA is not necessary if the following situations apply:

- The beneficiary is eligible for the other insurance,
- The other insurance covers the service, and
- Medicaid's only liability is the co-insurance, co-pay or deductible amounts up to our allowable fee screen (or)
- When no additional monies are due as the other payer provided payment in full.

PA is necessary for all other situations.

Extension of the PA Beyond Six Months:

To accommodate the PA process of DME rental items, additional time beyond the usual six month timeframe may be requested at the time the PA form is initially submitted for review. The number of additional months and reason for the request must be detailed on the form for consideration. As a result, the approved PA number could then be active for any date of service for up to twelve months.

- **Hospital Discharge Waiver Services**

Hospital Discharge Waiver Services are specific DME items provided to the beneficiary for up to the first three months after hospital discharge. The Waiver Program (WP) modifier will no longer be required to bypass the need for prior authorization (PA). Instead, the hospital discharge date should be reported as eight digits in Box 18 of the HCFA 1500 claim form. The following represents a list of DME items that may be billed immediately after hospital discharge without PA for up to three months. If provided after three months from the discharge date, the PA requirements as stated in the "Remarks" box still apply.

Nomenclature	HCPCS Procedure Code	Modifier	Remarks
COMMODE CHAIR, STATIONARY, WITH FIXED ARMS	E0163	RR	Prior authorization required except for specified diagnoses: 340, 343-343.99, 359.0 – 359.1, and 806 – 806.39
COMMODE CHAIR, STATIONARY, WITH DETACHABLE ARMS	E0165	RR	Prior authorization required except for specified diagnoses: 340, 343-343.99, 359.0 – 359.1, and 806 – 806.39
AIR PRESSURE PAD OR CUSHION, NONPOSITIONING	E0176	RR	Prior authorization required
PRESSURE PAD, ALTERNATING WITH PUMP	E0180	RR	Prior authorization required except for specified diagnoses: 340, 343-343.99, 359.0 – 359.1, and 806 – 806.39
HOSPITAL BED, WITH SIDE RAILS, VARIABLE HEIGHT, HI-LO, WITHOUT MATTRESS	E0255	RR	Prior authorization required except for specified diagnoses: 340, 343-343.99, 359.0 – 359.1, and 806 – 806.39
HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS	E0256	RR	Prior authorization required
HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITH ANY TYPE SIDE WITH ANY TYPE RAILS, WITH MATTRESS	E0260	RR	Prior authorization required
HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT ANY TYPE SIDE RAILS, WITH MATTRESS	E0292	RR	Prior authorization required

Nomenclature	HCPCS Procedure Code	Modifier	Remarks
HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITHOUT SIDE RAILS, WITHOUT MATTRESS	E0293	RR	Prior authorization required
COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT WHICH IS NOT SELF-CONTAINED OR CYLINDER DRIVEN	E0565	RR	Prior authorization required
APNEA MONITOR	E0608	RR	Prior authorization required
PATIENT LIFT, HYDRAULIC, WITH SEAT OR SLING	E0630	RR	Prior authorization required
TRAPEZE BARS, A/D/A/ PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR	E0910	RR	Prior authorization required except for specified diagnoses: 340, 343-343.99, 359.0 – 359.1, and 806 – 806.39
TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR	E0940	RR	Prior authorization required
STANDARD WHEELCHAIR	K0001	RR	Prior authorization required. Wheelchair options/accessories may be billed in addition to this code
STANDARD HEMI (LOW SEAT) WHEELCHAIR	K0002	RR	Prior authorization required. Wheelchair options/accessories may be billed in addition to this code
LIGHTWEIGHT WHEELCHAIR	K0003	RR	Prior authorization required. Wheelchair options/accessories may be billed in addition to this code
HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR	K0004	RR	Prior authorization required. Wheelchair options/accessories may be billed in addition to this code
DETACHABLE, ADJUSTABLE HEIGHT ARMREST, COMPLETE ASSEMBLY, EACH	K0016	RR	Prior authorization required
MANUAL, FULLY RECLINING BACK	K0028	RR	Prior authorization required.
ELEVATING LEGREST, COMPLETE ASSEMBLY	K0048	RR	Prior authorization required except for repairs or replacements only
WHEEL LOCK EXTENSION, PAIR	K0079	RR	Prior authorization required except for repairs or replacements only
APNEA MONITOR (ENHANCED MODEL)	Y4461	RR	Prior authorization required
PNEUMOGRAM	Y4463	RR	Prior authorization required

- **New Procedure Codes and Modifiers for Selected Contoured and Custom Back Systems for Wheelchairs**

Effective for dates of service on and after February 1, 2002, Medical Suppliers, Orthotists, and Prosthetists must use new HCPCS procedure codes and modifiers when billing for **selected** contoured and custom back systems for wheelchairs. The new procedure codes and descriptions are listed in the following table. **There are no other changes in policy or parameters for coverage of these services.**

HCPCS Procedure Code	Nomenclature	Replaces Existing Procedure Code and Modifier
K0114	Back support system for use with a wheelchair, with inner frame, prefabricated	Y4289 MM Y4291 MM
K0115	Seating system, back module, posterior-lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base	Y4289 G Y4291 G
K0116	Seating system, combined back and seat module, custom fabricated for attachment to wheelchair base	Y4296 G

Manual Maintenance

Retain this bulletin for future reference.

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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