



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth



MASSHEALTH
TRANSMITTAL LETTER OXY-25
July 2004

TO: Oxygen and Respiratory Therapy Equipment Providers Participating in MassHealth
FROM: Beth Waldman, Medicaid Director *BW*
RE: *Oxygen and Respiratory Therapy Equipment Manual* (Revised Service Codes)

This letter transmits a substantially revised Subchapter 6, including covered service codes, for the *Oxygen and Respiratory Therapy Equipment Manual*. This Transmittal Letter replaces Transmittal Letter OXY-23, issued last April, and Transmittal Letter OXY-24. (Please Note: In January 2004, the Division of Health Care Finance and Policy rescinded regulations that had been promulgated the same month, which made TL OXY-24 invalid.) The revised Subchapter 6, and the billing and prior authorization (PA) instructions and guidelines appearing below, are effective for dates of service on and after July 1, 2004.

MassHealth local codes and miscellaneous codes have been replaced with codes that are compliant with the Health Insurance Portability and Accountability Act (HIPAA), of 1996.

Subchapter 6 now lists all covered service codes in alphanumeric order. Descriptions of codes are no longer included. Providers should refer to www.cms.hhs.gov for code descriptions. Subchapter 6 is organized as follows.

- 601 Covered Services
- 602 Modifiers
- 603 Place-of-Service Codes
- 604 Payment Categories

Revised Fee Schedule

In June 2004, the Division of Health Care Finance and Policy (DHCFP) issued revised regulations certifying new fees and payment methodologies for the services and products in Subchapter 6 of the *Oxygen and Respiratory Therapy Equipment Manual*. The new fees and methodologies are effective for dates of service on and after July 1, 2004. The DHCFP regulations, including the fee schedule, are available on the DHCFP Web site at www.mass.gov/dhcfp.

Among other methodology changes, the new DHCFP fee schedule no longer includes the so-called third payment methodology for those services for which a fee has been established within the regulation. The established rate for these services is now the provider's usual and customary charge, or the rate established by DHCFP, whichever is lower. This change means that providers are no longer required to submit an invoice with a PA request or a claim in most instances. Providers must now submit only an invoice for a PA or a claim for services that are priced on an individual consideration (I.C.) basis. These services are listed as I.C. in the DHCFP fee schedule and in Subchapter 6 of the *Oxygen and Respiratory Therapy Equipment Manual*.

If you wish to obtain a paper copy of the fee schedule, you may purchase the schedule from either the Massachusetts State Bookstore or from DHC FP (see addresses and telephone numbers below). You must contact them first to find out the price of the regulation. The DHC FP also has the regulations available on disk. The regulation title for *Durable Medical Equipment and Oxygen and Respiratory Therapy Equipment* is 114 CMR 22.00.

Massachusetts State Bookstore
State House, Room 116
Boston, MA 02133
Telephone: 617-727-2834
www.mass.gov/sec/spr

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116
Telephone: 617-988-3100
www.mass.gov/dhcfp

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Impact of Effective Date of Subchapter 6 on Claims

Effective for dates of service on and after July 1, 2004, providers must bill for services provided to MassHealth members using only the HCPCS specified in the attached Subchapter 6. In addition to the new codes, providers must also use a modifier with certain codes to accurately reflect the service provided, and ensure the appropriate payment.

Claims submitted with codes not included in Subchapter 6 will be denied as not covered.

Impact of Effective Date of Subchapter 6 on Prior Authorization (PA)

Effective for dates of service on and after July 1, 2004, all requests for PA must be submitted using the new codes appearing in this new Subchapter 6. Providers who have already received PAs using now obsolete codes must request a new PA. When requesting a new PA for services already approved by MassHealth as medically necessary, providers should reference the old PA number. Providers should also indicate the new code, the number of units already billed, any remaining units needed (not to exceed the units on the original PA decision), and provide a copy of the physician's prescription submitted with the old PA.

Providers who have already received PAs with new codes that can be used after July 1, 2004, do not need to request a new PA.

Providers are reminded that PA requests require an ICD-9-CM code that directly relates to the services being requested, along with a description of the diagnosis.

Service Code Limits

Section 601 of Subchapter 6 identifies the payment category, indicates whether prior authorization (PA) is required, and specifies other requirements and limits for each code. The limits were developed in consultation with clinical experts and are based on generally accepted clinical practice guidelines.

Providers may submit a PA request for all members, for all services (even if a PA is not typically required for the service), for coverage of additional units beyond the specified guidelines if additional units are medically necessary. The request must be submitted before the additional units are provided, and must be supported by medical documentation.

New Billing and PA Requirements

Diagnosis Codes

ICD-9 CM codes are required on all claims. The ICD-9-CM code must be directly related to the service billed on the claim.

Services Provided to Members Aged 21 and Under and for Which No Code Appears in Subchapter 6

Miscellaneous codes have been removed from Subchapter 6 except where noted. If a member is aged 21 or under, and has a medically justified need for a product that is not listed in Subchapter 6, the provider should refer to MassHealth's Administrative and Billing Regulations at 130 CMR 450.000 for the EPSDT PA process.

To receive payment for any service described in 130 CMR 450.144(A)(1) that is not specifically included as a covered service under any MassHealth regulation, service code list, or contract, the requester must submit a request for prior authorization in accordance with 130 CMR 450.303. This request must include, without limitation, a letter and supporting documentation from a MassHealth-enrolled physician or nurse practitioner documenting the medical need for the requested service. If MassHealth approves such a request for service for which there is no established payment rate, MassHealth will establish the appropriate payment rate for such service on an individual-consideration basis in accordance with 130 CMR 450.271.

Services Purchased as Capped Rental for Members with MassHealth Coverage Only

For equipment considered capped rental, modifiers NU (new purchase) and UE (used equipment purchase) can be substituted for the KH, KI, KJ, and BP modifiers accepted by Medicare. If a member is covered by MassHealth only, and there is written medical documentation to justify the ongoing need of the equipment, providers can bill using the NU or UE modifier (whichever is applicable) to purchase the equipment for a MassHealth member. Providers do not have to bill over a 15-month period. However, if a member has other insurance, a provider must follow the primary insurer's payment methodology when billing MassHealth.

Supplies for Capped Rental Equipment

BIPAP and CPAP

Providers are required to provide all accessories for the initial setup of BIPAP and CPAP. Providers cannot bill for the disposable supplies for the initial set up separately. If the member has other insurance, and the equipment is being billed over a 15-month period, MassHealth will pay for disposable supplies according to the limits set forth in Subchapter 6 of the *Oxygen and Respiratory Therapy Equipment Manual*.

Suction

Providers are required to provide all accessories for the initial setup of suction equipment. Providers cannot bill for the disposable supplies for the initial set up separately, except for tracheal suction catheters and oropharyngeal suction catheters. If the member has other insurance and the equipment is being billed over a 15-month period, MassHealth will pay for disposable supplies according to the limits set forth in Subchapter 6 of the *Oxygen and Respiratory Therapy Equipment Manual*.

Inexpensive and Routinely Purchased DME

Certain HCPCS codes listed in Subchapter 6 require the modifier NU (new), RR (rental), or UE (used equipment). Providers are reminded that the RR modifier is for short-term use only. The rate attached to the RR modifier can never exceed the cost of purchasing the equipment new or used.

Repairs

Providers must use Service Code E1340 RP for repair of equipment not under warranty.

A PA is required for all repairs in all settings when the fee for the repairs will exceed \$1000. A prescription is not required for repair of equipment that was previously approved as medically necessary by MassHealth.

An itemized bill, indicating parts and labor, must be submitted to support claims for repairs. Payment for repairs will be a lump-sum payment that cannot exceed the purchase price of a new item, or the payment that would be necessary to rent a replacement item for the remaining period for which the product has been determined to be medically necessary.

Claims submitted for repairs must use Service Code E1340 and the RP modifier, must be billed in 15-minute increments, and must be supported by the following information:

- a description of the repair;
- an explanation as to why the repair is medically necessary;
- an itemization of parts and labor; and
- invoices for all parts.

Prescription Requirements for Services Provided to Members Who Are in Nursing Facilities

A prescription from a physician on a prescription pad or physician's letterhead is no longer required when providing services to MassHealth members who are in nursing facilities. Instead, providers are required to submit a copy of the order from the member's medical record, along with any treatment plan that pertains to the equipment being requested (e.g., SPO2, sleep study, and /or ambulatory status) written by the facility's staff.

Place-of-Service Codes

Section 602 of Subchapter 6 identifies covered place-of-service codes for each HCPCS code. Please refer to Section 604 in Subchapter 6 for the crosswalk to the appropriate place-of-service codes if billing HIPAA-compliant transactions. This crosswalk should be referenced only for HIPAA transactions, and should not be used for paper claims.

Providers are reminded that the place of service is where the product is used (e.g., member's home, nursing facility, or rest home). For a member residing in a group home, providers are required to use the code for home. The PA, if applicable, and the claim must reflect the accurate place of service. Providers are reminded that MassHealth does not pay an oxygen and respiratory therapy equipment provider for equipment and supplies provided to MassHealth members in institutions licensed as acute, chronic, or rehabilitation hospitals.

Individual Consideration (I.C.)

Providers must submit an invoice for claims for services that are I.C. Providers are required to enter the acquisition cost, plus the appropriate mark-up, in the "usual fee" data element, and provide a complete description of the service in the "remarks" data element.

Billing for Oxygen and Respiratory Therapy Equipment for Which Multiple PA Numbers Have Been Issued

In certain instances, PAs require multiple lines. MassHealth's Automated PA System (APAS) can accommodate an unlimited number of HCPCS codes on a PA request. However, in situations where a PA requires more than 5 lines, providers will receive more than one PA number for the requested equipment. Providers are reminded when billing for services, the correct PA number must correspond to the appropriate service being billed.

Oximeters

Effective for dates of service on and after July 1, 2004, MassHealth will no longer differentiate between a portable (spot check) oximeter and a stationary oximeter (with alarms). MassHealth will use one code and pay one fee as indicated in DHCFP's regulation. MassHealth will no longer price claims for this product by considering a provider's adjusted acquisition cost.

Oxygen Liter Flow Greater Than 4 LPM

Effective for dates of service on and after July 1, 2004, providers are required to use modifiers QF and QG for liter flows 4 LPM or greater. If basic oxygen criteria is met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study is performed while the patient is on the 4 LPM, and meets the Group 1 or Group 2 criteria as defined in Tricenturion's Current Local Medical Review Policies (LMRP) [www.tricenturion.com]. Initial coverage is limited to 3 months or the physician-specified length of need, whichever is shorter. Subsequent renewals require a blood-gas study performed on 4 LPM, and is limited to 6 months to ensure the patient meets Criteria 1 and 2.

Providers are reminded that the qualifying blood-gas study must be performed by a provider who is qualified to bill for the test (i.e., a laboratory, independent diagnostic testing facility (IDTF), or a physician.) A MassHealth oxygen and respiratory therapy equipment provider is not considered a qualified provider or a qualified laboratory.

Phototherapy (Bilirubin)

Effective for dates of service on and after July 1, 2004, phototherapy does not require a PA and will be paid on a per-episode basis as indicated in DHCFP's regulation.

Apnea Monitor

Effective for dates of service on and after July 1, 2004, MassHealth no longer requires a PA for the first three months of rental for an apnea monitor. Claims for the first three months must be submitted with KH (initial claim) and KI (claim months 2 and 3) modifiers. After three months of use, providers are required to download the memory, and send the report to the ordering physician for the interpretation of the events.

If the physician has determined the equipment is required for more than three months, the provider must request a PA from MassHealth. The provider must submit a copy of the signed physician's interpretation, noting any and all events using the KJ modifier, and indicate the initial dates of service.

An apnea monitor is priced using the capped rental payment methodology. MassHealth will pay a monthly rental fee for up to 15 months as indicated in DHCFP's regulation. This equipment remains a covered item after 15 months, but the provider should not bill MassHealth, as MassHealth will not pay a monthly rental fee after the 15th month. If the equipment is provided for 15 months or more, the provider must use the modifier BR on the claim for the 15th month to indicate that is the last claim for a monthly rental fee.

The provider must retain ownership of the equipment and continue providing the equipment to the member without any charge until either the medical necessity for the equipment ends, or the eligibility of the member for MassHealth ends, whichever is sooner.

Claims for Custom-Made Goods Provided to Members Who Become Ineligible

As stated in 130 CMR 450.231(B), "the 'date of service' is the date on which a medical service is furnished to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers to member medical goods, that had to be ordered, fitted, or altered for the member, and the member ceases to be eligible for such MassHealth services on a date before the final delivery of the goods, the Division will pay the provider for the goods...."

Providers must submit paper claims for these services with all applicable documentation outlined in 130 CMR 450.231(B) to the following address.

MassHealth
Claims Operations Unit
Attention: After Cancel Unit
600 Washington Street
Boston, MA 02111

Members with Other Insurance

If MassHealth is a secondary payer, all claims submitted to MassHealth must be billed to MassHealth with the same HCPCS code as was billed to the other primary insurer. MassHealth denies all claims for services provided to members with other insurance if those claims are billed using Service Code A9270.

If a service code is never covered by a primary insurer, but is covered by MassHealth, an explanation of benefits (EOB) is not required when billing MassHealth. For example, Medicare does not cover diapers. If the member is covered by Medicare, the provider does not have to bill Medicare first, and can bill MassHealth directly. MassHealth pays up to the MassHealth amount, or the member's responsibility, whichever is less.

If a service code is covered by Medicare, but not in the place of service in which the service was provided, the provider must obtain a letter from CMS, annually, that indicates that the specific code is not covered by Medicare in the specific setting. For example, oxygen is a service that is covered by Medicare, but it is not covered in a nursing facility. If the member is covered by Medicare, the provider must obtain a letter from CMS, annually, to submit in support of each claim.

Medical Necessity Documentation

Medical necessity determinations are based on specific clinical information and documentation that supports appropriate medical use of the services being requested.

When documenting medical necessity, a provider should include at least the following information:

- the member's diagnosis;
- a summary of the member's medical history and results of physical exam from medical records. Current test results, lab reports, and visiting nurses' notes are examples of appropriate supporting documentation.
- a description of the severity of the medical problem (acute, chronic, stable) and clinical findings to support this;
- whether the medical condition is life threatening; and
- whether the member's medical status or condition is permanent or reversible.

MassHealth requires medical necessity documentation to demonstrate that the service will contribute to the member's treatment or recovery process.

Noncovered Services

Providers are reminded that air conditioners, HEPA filters, light boxes, and disposable washcloths (baby wipes) are not covered by MassHealth.

Case Management for Complex-Care Members

Beginning August 1, 2003, the *Home Health Agency Manual* was revised to include a new initiative for MassHealth members under the age of 22 who require a nurse encounter of more than two continuous hours. MassHealth refers to these members as complex-care members.

The new initiative, called Community Case Management (CCM), assigns each complex-care member a case manager who performs a comprehensive needs assessment and authorizes all medically necessary home health and other community services, including oxygen and respiratory therapy equipment, for these members. The Recipient Eligibility Verification System (REVS) will identify those complex-care members whom MassHealth has enrolled in CCM.

All requests for PA for members enrolled in CCM are reviewed and authorized by the case manager assigned to the member. PA requests received from providers are automatically forwarded to the appropriate case manager for review. Providers must continue to follow the PA process as outlined in the MassHealth regulations in Subchapter 4 of the *Oxygen and Respiratory Therapy Equipment Manual*. The case manager is responsible for direct interaction with the prescriber to ensure proper documentation is received.

Questions

Providers with questions about this information may contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

NEW MATERIAL

(The pages listed here contain new or revised language.)

Oxygen and Respiratory Therapy Equipment Manual

Pages vi and 6-1 through 6-10

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

Oxygen and Respiratory Therapy Equipment Manual

Pages vi and 6-1 through 6-10— transmitted by Transmittal Letter OXY-24

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE TABLE OF CONTENTS	PAGE vi
	TRANSMITTAL LETTER OXY-25	DATE 07/01/04

6. SERVICE CODES

601 Covered Services	6-1
602 Modifiers.....	6-7
603 Place-of-Service Codes.....	6-8
604 Payment Categories	6-8
Appendix A. DIRECTORY	A-1
Appendix B. ENROLLMENT CENTERS	B-1
Appendix C. THIRD-PARTY-LIABILITY CODES	C-1
Appendix W. EPSDT SERVICES: MEDICAL PROTOCOL AND PERIODICITY SCHEDULE.....	W-1
Appendix X. FAMILY ASSISTANCE COPAYMENTS AND DEDUCTIBLES	X-1
Appendix Y. REVS CODES/MESSAGES	Y-1
Appendix Z. EPSDT SERVICES LABORATORY CODES	Z-1

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES	PAGE 6-1
	TRANSMITTAL LETTER OXY-25	DATE 07/01/04

601 Covered Services

Subchapter 6 contains, service codes, modifiers and descriptions, place-of-service codes, attachment requirements, and categories.

Providers may submit a prior-authorization request for all members for coverage of additional units, if additional units are medically necessary. The request should be submitted before the additional units are provided, and must be supported by medical documentation.

<u>Service Code</u>	<u>Payment Category</u>	<u>Modifiers Required</u>	<u>PA Required?</u>	<u>POS Required</u>	<u>Requirements and Limits</u>
A4216	OS	NU	No	02 07	1 unit = each, 100 per month
A4217	OS	NU	No	02 07	1 unit = each, 31 per month
A4481	OS	NU	No	02 07	ICD-9-CM V44.0 or V55.0
A4556	SU	NU	No	02 07	A4556 can be billed separately from E0619.
A4557	SU	NU	No	02 07	A4557 can be billed separately from E0619.
A4558	SU	NU	No	02 07	1 unit = each, 1 per 3 months
A4606	IN	NU	Yes	02 07	1 unit = each, 1 per 12 months
A4608	OX	NU	Yes	02 07	1 unit = each, 2 per 3 months. ICD-9-CM V44.0 or V55.0
A4609	IN	NU	Yes	02 07	1 unit = each, 11 per month (not to be used with A4624 and E0200). Can be billed separately when using E0600. ICD-9-CM V44.0 or V55.0 required for use.
A4610	IN	NU	Yes	02 07	1 unit = each, 6 per month (not to be used with A4624 and E0200). Can be billed separately when using E0600 ICD-9-CM V44.0 or V55.0 required for use.
A4611	IN	NU RR UE	Yes	02 07	1 unit = each, 1 per 36 months
A4612	IN	NU RR UE	Yes	02 07	1 unit = each, 1 per 12 months
A4613	IN	NU RR UE	Yes	02 07	1 unit = each, 1 per 12 months
A4614	IN	-- --	No	02 07	1 unit = each
A4619	OX	-- --	No	02 07	1 unit = each, 1 per month (used with E0565 and E0585).
A4623	OS	-- --	No	02 07	1 unit = each; ICD-9-CM V44.0 or V55.0
A4624	IN	NU	No	02 07	1 unit = each, 150 per month (can be billed separately for use with E0600, not for use with E2000); ICD-9-CM V44.0 or V55.0
A4625	OS	-- --	No	02 07	1 unit = each, 14 per post-op episode (A4625 is to be used only two weeks post-operatively; after two weeks use A4629.)
A4626	OS	-- --	No	02 07	1 unit = each, 31 per month (included in A4625 and A4629 and cannot be billed separately).

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES		PAGE 6-2
	TRANSMITTAL LETTER OXY-25		DATE 07/01/04

601 Covered Services (cont.)

<u>Service Code</u>	<u>Payment Category</u>	<u>Modifiers Required</u>	<u>PA Required?</u>	<u>POS Required</u>	<u>Requirements and Limits</u>
A4627	IN	NU	No	02 07	1 unit = each, 1 per 3 months
A4628	IN	NU	No	02 07	1 unit = each, 4 per month (Can be billed separately from E0600.)
A4629	OS	-- --	No	02 07	1 unit = each, 31 per month
A7000	IN	-- --	No	02 07	1 unit = each, 1 per month (A7000 can be billed separately from E6000.)
A7001	IN	-- --	No	02 07	1 unit = each, 1 per month (A7001 can be billed separately from E6000.)
A7002	IN	-- --	No	02 07	1 unit = each, 1 per month (A7002 can be billed separately from E6000, but not if it is included in A7001.)
A7003	IN	NU	No	02 07	1 unit = each, 2 per month (A7003 can be billed separately when used with E0570 only when the patient owns equipment; otherwise A7003 is included in rental.)
A7004	IN	NU	No	02 07	1 unit = each, 2 per month (A7004 can be billed separately when used with E0570 or A7003.)
A7005	IN	NU	No	02 07	1 unit = each, 1 per 6 months (A7005 can be billed separately when used with E0570.)
A7006	IN	NU	No	02 07	1 unit = each, 1 per month (A7006 can be billed separately when used with E0565, E0570, or E0585.)
A7010	IN	NU	No	02 07	1 unit = each (100 ft.), 2 per month (A7010 can be billed separately when used with E0565 or E0585.)
A7011	IN	NU	No	02 07	1 unit = each (10 ft.), 1 per 12 months (A7011 can be billed separately when used with E0565 or E0585 only when patient owns equipment; otherwise A7011 is included in monthly rental.)
A7012	IN	NU	No	02 07	1 unit = each, 2 per month (A7012 can be billed separately when used with E0565 or E0585 only when patient owns equipment; otherwise A7012 is included in monthly rental.)
A7013	IN	NU	No	02 07	1 unit = each, 2 per month (A7013 can be billed separately when used with E0565, E0570, or E0585 only when patient owns equipment; otherwise A7013 is included in monthly rental.)
A7014	IN	NU	No	02 07	1 unit = each, 1 per 3 months (A7014 can be billed separately when used with E0565, E0572, or E0585 only when patient owns equipment; otherwise A7014 is included in monthly rental.)

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES		PAGE 6-3
	TRANSMITTAL LETTER OXY-25		DATE 07/01/04

601 Covered Services (cont.)

<u>Service Code</u>	<u>Payment Category</u>	<u>Modifiers Required</u>	<u>PA Required?</u>	<u>POS Required</u>	<u>Requirements and Limits</u>
A7015	IN	NU	No	02 07	1 unit = each, 1 per month (A7015 can be billed separately when used with E0565, E0570, or E0585.)
A7017	IN	NU RR UE	No	02 07	1 unit = each, 1 per 36 months (A7017 can be billed separately when used with E0565 or E0572 only when patient owns equipment; otherwise A7017 is included in monthly rental.)
A7018	SU	-- --	No	02 07	1 unit (1000 ml.) = each, 15 per month
A7025	IN	NU	Yes	02 07	1 unit = each, 1 per 3 years
A7026	IN	NU	Yes	02 07	1 unit = each, 1 per 3 years
A7030	IN	NU	No	02 07	1 unit = each, 1 per 3 months (used with E0601, K0532, or K0533)
A7031	IN	NU	No	02 07	1 unit = each, 1 per 3 months (used with E06001, K0532, or K0533)
A7032	IN	NU	No	02 07	1 unit = each, 2 per month (used with E06001, K0532, or K0533)
A7033	IN	NU	No	02 07	1 unit = each, 2 per month (used with E06001, K0532, or K0533)
A7034	IN	NU	No	02 07	1 unit = each, 1 per 3 months (A7034 is included in monthly rental and cannot be billed separately for 6 months after E06001, K0532, or K0533 has been purchased for the patient.)
A7035	IN	NU	No	02 07	1 unit = each, 1 per 6 months (used with E06001, K0532, or K0533)
A7036	IN	NU	No	02 07	1 unit = each, 1 per 6 months (used when E06001, K0532, or K0533 has been purchased for the patient.)
A7037	IN	NU	No	02 07	1 unit = each, 1 per month (used with E06001, K0532, or K0533)
A7038	IN	NU	No	02 07	1 unit = each, 2 per month (A7038 is included in monthly rental and cannot be billed separately for 6 months after E06001, K0532, or K0533 has been purchased for the patient.)
A7039	IN	NU	No	02 07	1 unit = each, 1 per 6 months (used with E06001, K0532, or K0533)
A7044	IN	NU	No	02 07	1 unit = each, 1 per 3 months
A7046	IN	NU	No	02 07	1 unit = each, 1 per 6 months (only when an appropriate humidifier has been purchased)
A7501	OS	-- --	No	02 07	1 unit = each, 1 per 6 months
A7502	OS	NU	No	02 07	1 unit = each, 1 per 6 months
A7503	OS	NU	No	02 07	1 unit = each, 2 per 12 months
A7504	OS	NU	No	02 07	1 unit = each, 90 per month (packages of 30)
A7505	OS	NU	No	02 07	1 unit = each, 4 per month

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES	PAGE 6-4
	TRANSMITTAL LETTER OXY-25	DATE 07/01/04

601 Covered Services (cont.)

<u>Service Code</u>	<u>Payment Category</u>	<u>Modifiers Required</u>	<u>PA Required?</u>	<u>POS Required</u>	<u>Requirements and Limits</u>
A7506	OS	NU	No	02 07	1 unit = each, 90 per month (packages of 30)
A7507	OS	NU	No	02 07	1 unit = each, 90 per month
A7508	OS	NU	No	02 07	1 unit = each, 90 per month
A7509	OS	NU	No	02 07	1 unit = each, 90 per month
A7520	OS	NU	No	02 06 07	1 unit = each, 1 per 3 months
A7521	OS	NU	No	02 06 07	1 unit = each, 1 per 3 months
A7522	OS	NU	No	02 06 07	1 unit = each, 1 per 12 months
A7524	OS	NU	No	02 06 07	1 unit = each, 1 per 6 months
A7525	OS	NU	No	02 07	1 unit = each, 1 per month, ICD-9-CM V44.0 or V55.0
A7526	OS	NU	No	02 07	1 unit = each, 5 per month (A7526 is included in A4625 and A4629 and cannot be billed separately.)
E0424	OX	RR	Yes	02 06 07	Qualifying ABGs or SPO2 within 2 days of discharge from facility or within 30 days of new or renewal order.
E0431	OX	RR	Yes	02 06 07	Qualifying ABGs or SPO2 within 2 days of discharge from facility or within 30 days of new or renewal order. Documentation of hours away from stationary required.
E0434	OX	RR	Yes	02 06 07	Qualifying ABGs or SPO2 within 2 days of discharge from facility or within 30 days of new or renewal order. Documentation of hours away from stationary required.
E0439	OX	RR QE QG	Yes	02 06 07	Qualifying ABGs or SPO2 within 2 days of discharge from facility or within 30 days of new or renewal order. ABG required for liter flow of 4 LPM or above. Maximum allowed PA approval for 4 LPM or above is 3 months.
E0445	IN	NU RR UE	Yes	02 07	Covers portable or monitor, for use when SPO2 is transient, variable, and unpredictable, even in the presence of supplemental oxygen, and occurs on a regular basis requiring frequent changes in liter flow.
E0450	FS	RR	Yes	02 06 07	RR modifier is to be used for any existing equipment that has an initial date prior to 07/01/04 and/or rental months 7 and above after 07/01/04.
E0450	FS	U2	Yes	02 06 07	U2 modifier is for use on rental months 1 through 6 only (not to be used if member has had this equipment prior to 07/01/04); otherwise RR modifier is to be used.
E0454	FS	RR	Yes	02 06 07	-- --

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES		PAGE 6-5
	TRANSMITTAL LETTER OXY-25		DATE 07/01/04

601 Covered Services (cont.)

<u>Service Code</u>	<u>Payment Category</u>	<u>Modifiers Required</u>	<u>PA Required?</u>	<u>POS Required</u>	<u>Requirements and Limits</u>
E0457	IN	NU RR UE	Yes	02 06 07	1 unit = each, 1 per 5 years
E0459	CR	KH KI KJ BP NU UE	Yes	02 06 07	1 unit = each, 1 per 5 years
E0460	FS	RR	Yes	02 06 07	-- --
E0461	FS	RR	Yes	02 06 07	RR modifier is to be used for any existing equipment that has an initial date prior to 07/01/04 and/or rental months 7 and above after 07/01/04.
E0461	FS	U2	Yes	02 06 07	U2 modifier is for use on rental months 1 through 6 only (not to be used if member has had this equipment prior to 07/01/04); otherwise RR modifier is to be used.
E0470	IN	KH KI KJ BP NU UE	Yes	02 07	The physician must document therapeutic benefit and compliance of equipment use after the first 90 days of use.
E0471	IN	KH KI KJ BP NU UE	Yes	02 07	The physician must document therapeutic benefit and compliance of equipment use after the first 90 days of use.
E0480	CR	KH KI KJ BP NU UE	Yes	02 07	1 unit = each, 1 per 5 years
E0482	CR	KH KI KJ BP NU UE	Yes	02 07	1 unit = each, 1 per 5 years. ICD-9-CM 335.0 – 335.9, 340, 344.00 – 344.09, 359.0, 359.1 V4.0 or V55.0 (used to clear secretions for patients who cannot clear themselves).
E0483	CR	KH KI KJ BP NU UE	Yes	02 07	1 unit = each, 1 per 5 years (used for patients that have the ability to clear their own secretions).
E0484	IN	NU RR UE	Yes	02 07	1 unit = each, 1 per 12 months (used for patients that have the ability to clear their own secretions).
E0500	FS	RR	Yes	02 07	-- --
E0550	CR	KH KI KJ BP NU UE	Yes	02 07	1 unit = each, 1 per 5 years. E0550 is included in oxygen delivery systems and cannot be billed separately.
E0560	IN	NU RR UE	Yes	02 07	1 unit = each, 1 per 5 years
E0561	IN	NU RR UE	Yes	02 06 07	Included in rental of E0601, E0470, and E0471 (Can be purchased on last month rental of E0601, E0470, and E0471.)

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES		PAGE 6-6
	TRANSMITTAL LETTER OXY-25		DATE 07/01/04

601 Covered Services (cont.)

<u>Service Code</u>	<u>Payment Category</u>	<u>Modifiers Required</u>	<u>PA Required?</u>	<u>POS Required</u>	<u>Requirements and Limits</u>
E0562	IN	NU RR UE	Yes	02 06 07	Included in rental of E0601, E0470, and E0471 (Can be purchased on last month rental of E0601, E0470, and E0471.)
E0565	CR	KH KI KJ BP NU UE	Yes	02 06 07	Accessories associated with E0565 are A4619, A4621, A7006, A7011, A7012, A7013, A7014, A7015, A7017, and E1372.
E0570	CR	KH KI KJ BP NU UE	No	02 07	Accessories associated with E0570 are A4621, A7003, A7004, A7005, A7006, A7013, and A7015.
E0572	CR	KH KI KJ BP NU UE	Yes	02 07	Accessories associated with E0572 are A7006 and A7014.
E0585	CR	KH KI KJ BP NU UE	Yes	02 07	Accessories associated with E0585 are A4619, A4621, A7006 A7010, A7011, A7012, A7013, A7014, and A7015.
E0600	CR	KH KI KJ BP NU UE	Yes	02 07	1 unit = each, 1 per 5 years. Physician must document therapeutic benefit for renewal after 90 days.
E0601	CR	KH KI KJ BP NU UE	Yes	02 06 07	1 unit = each, 1 per 5 years
E0605	IN	NU RR UE	No	02 07	1 unit = each, 1 per 24 months
E0606	CR	KH KI KJ BP NU UE	No	02 07	1 unit = each, 1 per 5 years
E0619	CR	KH KI KJ BR	No	02 07	PA required after 3 months of use (After three months of use providers are required to download the memory, and send the report to the ordering physician for interpretation of events.)
E1340		RP	No	02 07	PA required for any repair of equipment over \$1,000.00 no matter what POS.
E1372	IN	NU RR UE	Yes	02 07	1 unit = each, 1 per 36 months (
E1390	OX	RR QE QG	Yes	02 06 07	Qualifying ABGs or SPO2 within 2 days of discharge from facility or within 30 days of new or renewal order. ABG required for liter flow of 4 LPM or above. Maximum allowed PA approval for 4 LPM or above is 3 months.
L8501	IN	-- --	No	02 07	ICD-9-CM V44.0 or V55.0
S8180	IN	-- --	No	02 07	ICD-9-CM V44.0 or V55.0
S8181	IN	-- --	No	02 07	ICD-9-CM V44.0 or V55.0
S8185	IN	-- --	No	02 07	1 unit = each, 1 per 6 months
S8186	IN	-- --	No	02 07	1 unit = each, 1 per month

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES	PAGE 6-7
	TRANSMITTAL LETTER OXY-25	DATE 07/01/04

601 Covered Services (cont.)

<u>Service Code</u>	<u>Payment Category</u>	<u>Modifiers Required</u>	<u>PA Required?</u>	<u>POS Required</u>	<u>Requirements and Limits</u>
S8190	IN	NU RR UE	Yes	02 07	ICD-9-CM V42.6 post-operative lung transplants only
S8210	IN	-- --	Yes	02 07	1 unit = each, 31 per month
S8999	IN	NU	No	02 07	ICD-9-CM V44.0 or V55.0 (S8999 can be used in conjunction with E0450, E0454, and E0461.)

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES	PAGE 6-8
	TRANSMITTAL LETTER OXY-25	DATE 07/01/04

602 Modifiers

Modifier Description

BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item (For MassHealth members, MassHealth has purchased the item for the member.) (used on the 15 th month of capped rental)
BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item (For Mass Health members, member continues to rent, no more claims can be submitted, purchase price has been met. MassHealth will not purchase the item.) (used on the 15 th month of rental)
KH	DME POS item, initial claim, purchase or first month rental (For MassHealth member's first claim.)
KI	DME POS item, second or third month rental
KJ	DME POS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to 15 (for MassHealth members months four through 14)
KR	Rental item, billing for partial month
NR	New when rented (Use the NR modifier when DME that was new at the time of the rental is subsequently purchased.)
NU	New equipment
QE	Prescribed amount of oxygen is less than 1 liter per minute (LPM)
QF	Prescribed amount of oxygen exceeds 4 liters per minute (LPM) and portable is prescribed
QG	Prescribed amount of oxygen is greater than 4 liters per minute (LPM)
QH	Oxygen-conserving device is being used with an oxygen delivery system
RP	Replacement and repair - RP may be used to indicate replacement of DME, orthotic, and prosthetic devices that have been in use for some time. The claim shows the code for the part, followed by the RP modifier and the charge for the part.
RR	Rental (Use the RR modifier when DME is to be rented.)
U2	Modifier is used on rental months 1 through 6 (for designated HCPCS codes) (not to be used if member has had equipment prior to 07/01/04).
UE	Used durable medical equipment

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES	PAGE 6-9
	TRANSMITTAL LETTER OXY-25	DATE 07/01/04

603 Place-of-Service Codes

The following are codes and descriptions for paper or electronic submission.

Type of Claim	Place-of-Service Code	Description
Paper	02	Member's home
	06	Nursing home
	07	Rest home
Electronic	12	Home
	31, 32	Skilled nursing facility, nursing facility
	33	Custodial care facility

604 Payment Categories

Each covered service code is assigned to one of the following payment categories. These categories help providers to identify applicable modifiers, and explain how MassHealth pays for the service.

<u>Category</u>	<u>Description</u>
CAP	Capitated rate (per episode)
CR	Capped rental
FS	Frequently serviced items
IN	Inexpensive and routinely purchased DME
OS	Ostomy, tracheostomy, and urologicals
OX	Oxygen and oxygen equipment
PO	Prosthetics and orthotics
SU	Supplies

Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series OXYGEN AND RESPIRATORY THERAPY EQUIPMENT MANUAL	SUBCHAPTER NUMBER AND TITLE 6 SERVICE CODES	PAGE 6-10
	TRANSMITTAL LETTER OXY-25	DATE 07/01/04

604 Payment Categories (cont.)

Category Description

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