Durable Medical Equipment Billing Resource Tool

Claims – DME Billing Codes & Tips to Avoid Denials

This claims tool provides you with quick tips to avoid claim denials and how to resolve them when they occur. This is not an all-inclusive list of tips and solutions, but a snapshot of the top durable medical equipment (DME) claim denials. It is designed to give you resolution tips to help eliminate the issue from the first act of resolution. If you see that your claim has been denied and needs corrected, please send in the corrected claim(s) as quickly as possible to allow re-processing time.

Denial Reason	Code Examples	Explanation	Tips to Avoid Denials
Incorrect diagnosis code	F02.80 is a manifestation code and not the disease itself.	Diagnosis code used cannot be listed as the primary diagnosis	• Use current Dx codes reflected in your annual updates. • Review codes to make certain they can be used as primary diagnosis codes. • For more information regarding correct coding, refer to the Ohio Department of Medicaid (ODM) ICD-10 web page and Centers for Medicare & Medicaid Services' (CMS) ICD-10 web page.
Incorrect CPT/HCPC code	A4380, A4381 and A3382	Wrong codes selected for service rendered	• Review the service or supply rendered. • Compare your code choices with your prior authorization, if necessary. It's imperative to use your allowed codes given during your prior authorization process. • There are very similar codes available – be certain to select the one that is for your specific service. • Review codes on the Ohio Department of Job and Family Services' (ODJFS) website. • Review the Centers for Medicare & Medicaid Services' (CMS) ICD-10 web page.
Incorrect modifier use	Modifier LL and RR are commonly misused in rental/leasing services	Incorrect modifier usage, or missing modifier	• Modifiers are used to provider further detail for the CPT-HCPC code you're using, such as RT, LT, and bilateral. • Some codes require a modifier to be used and without these, your claim will deny, so be familiar with modifiers for DME. • For additional information, please see the ODM Modifiers Recognized by Ohio Medicaid guide. • Please also see CareSource's Reimbursement Modifiers policy.

Denial Reason	Code Examples	Explanation	Tips to Avoid Denials
Medically unlikely units denial (MUE)	N/A	Exceeding medically unlikely units	• MUE are the number of units typically provided in a day. When this is exceeded, there is a denial issued. A provider can reassess their coding to include modifiers that would explain why the units are being exceeded. • Review the MUE information at these websites: Data.Medicaid.gov CMS.gov
Prior authorization number missing	N/A	No authorization number included on claim	• Prior to submitting your claim to CareSource, make certain you've included the prior authorization number on your claim. This can be found in box 23 on your HCFA form. For further information, please go to CMS.gov.
No units submitted	Codes A4380-A4382	Units missing	• All codes require the units of the respective code that were supplied to the member. • Prior to submitting your claim to CareSource, make certain the units are completed and correct. • If your claim is submitted to CareSource without units, you will receive a denial.
Units billed exceed units authorized	Enteral supplied – A7015	Exceeding authorization	• You receive a claim denial for exceeding the units authorized. • Review your authorization for the units you were authorized for and submit a corrected claim. • If additional units are required for the member's care, contact Utilization Management. • For further information, see CMS.gov.
Eligibility Denial	N/A	Eligibility/termination	• Except for emergency services, providers are expected to verify member eligibility before providing services. • Remember members' eligibility can change frequently. • Make sure to check eligibility by going to the CareSource Provider Portal. • Eligibility can also be checked by calling Provider Services at: 1-800-488-0134.

CareSource has several different options if providers disagree with claims outcomes.

- The claim dispute process can be found on our Provider Portal.
- The appeal process is to be used only when appropriate. If there continued to be a disagreement with the dispute outcomes, the appeal process can be utilized. Log in to the Provider Portal for more information.

Prior Authorizations – DME Common Errors & Tips to Mitigate Errors

Prior authorization isn't always based solely upon medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness and benefit limits. The purpose of this tool is to optimize patient outcomes, ensure you are reimbursed timely, and overcome obstacles in the DME area. The tool below offers helpful hints and common errors found in DME prior authorizations.

Authorization Issue	Definition	Tips to Avoid Issues
Member eligibility	Authorization denial due to member eligibility	• Except for emergency services, providers are expected to verify member eligibility before providing services. • Remember members' eligibility can change frequently. • Check eligibility by going to the CareSource Provider Portal. • Eligibility can also be checked by calling Provider Services at: 1-800-488-0134.
Inadequate supporting documentation	Not enough information has been given to support the request for authorization for medical necessity approval	Always provide the following information: • Member/patient name and CareSource ID • Provider name and TIN/NPI • Anticipated date of service (DOS) • Diagnosis code and narrative • Procedure code/HCPCS code or service requested • Number of units, length of service requested • Clinical information to support the service requested
Excessive amount being requested	Items such as disposable underwear/pull-ons, etc. have limits	• To view Medicaid quantity limits prior to requesting prior authorization, please see the ODM fee schedule and rates. • There are also helpful items in the Provider Manual regarding prior authorizations, starting on page 32.
Failure to obtain prior authorization when one is necessary	There are some services that will always require a prior authorization and there are time limits for obtaining this.	• Always determine prior to providing services whether a prior authorization is necessary. • There are several ways to obtain prior authorization: Access the Provider Portal. Call Utilization Management at: 1-800-488-0134. Fax to 888-752-0012. Mail to CareSource at P.O. Box 1307, Dayton OH 45401-1307 • CareSource isn't able to pay for services in which prior authorization is required, but not obtained by the provider. • There are times when emergency request for prior authorization is needed. In these changes, please call the 24-hour nurse advice line at: 1-800-488-0134. More information can be found in the Provider Manual on page 40.

Authorization Issue	Definition	Tips to Avoid Issues
Annual Authorizations Reminder	N/A	• If you receive an approval for DME items for one year (i.e., enterals), it's crucial to verify eligibility before mailing out the products on a monthly basis. • An annual authorization doesn't guarantee payment if the member is no longer eligible.