Network Notification

Notice Date: March 9, 2020
To: Ohio Medicaid, Medicare and MyCare Providers
From: CareSource
Subject: DME Claim Coding Edits - UPDATE
Effective Date: April 6, 2020

Please note: *This notification is a revision to the previous network notification dated Dec. 4, 2019.*

Summary
CareSource performs ongoing review of claims data to ensure claims are processed accurately and efficiently, and to be consistent with the Ohio Department of Medicaid (ODM), Centers for Medicare and Medicaid Services (CMS) and national commercial standards regarding the acceptance, adjudication and payment of claims.

The additional durable medical equipment (DME) claim coding edits below have been identified as necessary to comply with correct coding and industry standard guidelines. Please ensure your claim submissions are in compliance with the edits to avoid delays of claims processing.

Rule	Description	Source/Reference
Medicare Abdominal Aortic Aneurysm Screening Limitation	Per Medicare guidelines, the frequency (once a lifetime) does not meet policy requirements for the procedure code (76706 or G0389)	CMS Claims Processing Manual, Chapter 19 AMA
Medicare Non-Covered Chiropractic Services	Per Medicare guidelines, procedures other than chiropractic manipulative treatments are not covered when billed by a provider with specialty 35 (Chiropractor)	Medicare Benefit Policy Manual, Chapter 15 Section 30.5
Bilateral Modifier 50 Billed With More than 1 Unit	Per Medicare guidelines, a bilateral procedure code submitted with modifier 50 and billed with more than 1 unit of service is inappropriate. Bilateral procedures billed with a modifier 50 should be billed with 1 unit of service.	Medicare Claims Processing Manual, Chapter 23 Section 20.9.3.2; Chapter 12 Section 40.7
Initial Preventive Physical Examination Frequency	Per Medicare guidelines, the frequency does not meet policy requirements for the procedure code (G0402, Once per lifetime.)	Medicare Claims Processing Manual, Chapter 18
Medicare Initial Preventive Physical Examination and Annual Wellness Visit Dates of Service Policy	Per Medicare guidelines, the initial preventive physical examination HCPCS code G0402 must be billed prior to the annual wellness visit code G0438 or G0439.	Medicare Claims Processing Manual, Chapter 12 Section 30.6.1.1.
Medicare Annual Wellness Visit (AWV) with an *Initial* Preventive	The annual wellness visit (G0438, initial) occurred within a year of an initial preventive physical exam.	CMS Transmittal R2575CP Medicare Claims Processing Manual, Chapter 18

Physical Exam (IPPE) in History Rule		
Medicare Annual Wellness Visit (AWV) *Subsequent* Visit Rule	The annual wellness visit (G0439, subsequent) occurred within a year of an initial preventive physical exam.	CMS Transmittal R2575CP Medicare Claims Processing Manual, Chapter 18
Procedure Age	Procedure not typical for a patient's age	National Medicaid National DME AMA AAP (American Academy of Pediatrics)
Inappropriate Age for Procedure	Procedure not typical for a patient's age	Medicaid Outpatient AMA AHA (American Hospital Association) CMS
Procedure not Typical with Patient Gender	Procedure code reported not Typical with Patient Gender	National Medicaid National DME AMA
Possible Duplicate Line by Provider with Procedure Exclusions System List	Procedure code (on the current claim line) is a possible duplicate of the same procedure code found on a history claim line performed by the same provider on the same day.	Validation NCCI
Diagnosis Age	Diagnosis Code(s) is not typical for patient's age.	National Medicaid National DME AMA
Diagnosis Not Typical for Gender	Diagnosis Code(s) is not typical for patient's gender.	ICD-9-CM; ICD-10-CM CMS Policy AMA
Medicare ICD9 Code Rule	Per CMS guidelines, ICD-9 codes cannot be billed with dates of service greater than 9/30/2015.	CMS Transmittal R9500TN National Medicaid National DME
Medicare ICD-10 Rule	Per CMS guidelines, ICD-9 codes and ICD-10 codes cannot be billed on the same claim.	CMS Transmittal R9500TN National Medicaid National DME
ICD-10-CM Primary Diagnosis Only	The ICD-10-CM code may only be used as first-listed or primary diagnosis position.	National DME ICD-10-CM Official Guidelines
Incontinence Garments and Related Supplies - Age Criteria	Per Medicare guidelines, the patient's age does not meet policy requirements for procedure and/or diag.	OAC 5160-10 Medical Supplies, DME, Orthoses, and Prosthesis providers
Medical Supplies and the Medicaid Supply List - BR	Per Medicaid guidelines, appropriate documentation must be submitted or reviewed to ensure proper billing.	OAC 5160-10 Medical Supplies, DME, Orthoses, and Prosthesis providers
DME Suction Pumps and Suctioning Supplies	Per Medicaid Guidelines, procedure code A4624 has an unbundle relationship with	OAC 5160-10-03 Medical Supplies and the Medicaid Supply List

Tracheal Suction Catheter	procedure code A4605 billed on a prior claim.	

Questions?
If you have questions regarding this notice, please contact Provider Services at **1-800-488-0134**. (Monday through Friday, 8 a.m. to 6 p.m. Eastern Standard Time).

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