Coders’ Desk Reference for HCPCS 2014
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Appeals, Grievances, and Sanctions

Medicare Appeals
Providers and suppliers of DMEPOS have the right to request an adjustment or review of a claim felt to be inaccurately or unfairly adjudicated by the Medicare or DME Medicare administrative contractor (DME MAC) entity. In most cases, it behooves the provider or supplier to have specific internal protocol established for these claim re-evaluation options. There are important steps to follow when pursuing a re-evaluation of a claim determination.

If a supplier requests a review or other type of appeal on a nonassigned claim, the request must be made in writing and a patient authorization must accompany the request. Without the appropriate patient authorization, the request will be denied. Acceptable review requests must also include the following pieces of information:

- Beneficiary name
- Beneficiary date of birth
- Medicare health insurance claim (HIC) number
- Name and address of provider/supplier of item/service
- Date of initial determination
- Date of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form)
- Item and/or service, if any, at issue in the appeal

If the Medicare contractor or DME MAC entity return an initial claim for DMEPOS services or items to the supplier or provider, calling it unprocessable, then there are no immediate appeal rights. The claim must be refiled as a new claim.

CMS has determined that appeal rights should be granted only to the initial claim determination. Some providers and suppliers had been submitting another claim to extend the appeal time frame. Additional claims that duplicate the originally denied claim will be rejected as duplicates. DME MAC remittance remarks and beneficiary notices will be changed to state that the claim was a duplicate of a previously processed claim and that there are no appeal rights for a duplicate claim.

DMEPOS Claims Adjustments
When a claim is processed incorrectly due to an error made by the DME MAC, the provider or supplier can request an adjustment to the claim. In most cases this can be done over the telephone with a DME MAC representative. Examples of DME MAC errors necessitating claims adjustments include the following:

- Incorrect date of death
- Incorrect number of DMEPOS units or services
- Incorrect date of service

DMEPOS Claims Reviews
If a patient, provider, or supplier is dissatisfied with a claim determination for DMEPOS, the dissatisfied party has the right to request an appeal of the claim adjudication. A request for a claims appeal is now more commonly called a request for a review. DMEPOS claims denied due to medical necessity may only be appealed through the review process; claim adjustments cannot be made to these claims.

Parties who hold the right to request a review of a claim include the following:

- The patient
- The patient's choice of a representative
- A provider or supplier who has accepted assignment
- A supplier responsible for indemnification
- Medicaid state agency or the party authorized to act on behalf of the Medicaid state agency

Medicare has a five-level appeals process and each level must be completed before an appeal can proceed to the next level. The five levels are (1) redetermination, (2) reconsideration, (3) administrative law judge, (4) Departmental Appeals Board (DAB) review Appeals Council and (5) federal court review. The first two levels of appeal are the quickest and least costly for both the contractor and
Reimbursement Guidelines

receivable (A/R). The fundamental structure of collections and A/R analysis begins with three key financial elements:

- Charges
- Adjustments
- Payments

Every provider and supplier's office should generate monthly financial information in these areas, either by a computerized billing system or by manual bookkeeping reports. These key elements, when used in the basic formulas provided in this section, will provide a snapshot of the provider and supplier's financial strength or weakness in terms of collections and A/R status.

Conducting Cost and Reimbursement Analyses

Becoming or remaining profitable when furnishing patients with DMEPOS items involves monitoring all aspects of the financial investment made to furnish those items. Patient charges, mandatory health insurance adjustments, and other types of adjustments and insurance and patient payments (reimbursements) must be meticulously followed and studied. Becoming or remaining profitable also involves tracking all associated costs for dispensing DMEPOS items. These costs are easy to track, and include a range of considerations from the actual purchase price of the DMEPOS item to the costs of any supplies used in furnishing the item. The payer must track reimbursement for the DMEPOS items because the profit margin for a single item of DMEPOS can vary greatly between one payer and another.

A cost and reimbursement analysis should be performed at least every six months, and no less than once every year.

DMEPOS Cost Study

The costs of furnishing DMEPOS items must be closely monitored, as many times escalating costs can out-rise reimbursement for those items, thereby nullifying any potential profits. If all of the costs are not tracked alongside the reimbursements, a deceptively healthy financial picture surrounding DMEPOS dispensing activities can emerge, fooling providers and suppliers into thinking the DMEPOS profit center is fiscally sound.

Typical costs associated with furnishing DMEPOS to patients, for both providers and suppliers, include the following:

- Actual item purchase price
- Shipping and freight charges
- Taxes
- Physician or provider time involved in the dispensation process
- Staff time involved in the dispensation process
- Office or medical supplies expended when ordering, receiving, and furnishing the items

Most of the information needed to perform the cost study is taken directly from the invoices for the DMEPOS items. Using a computerized spreadsheet gives the provider or supplier the ability to assign formulas to each cell for automatic calculations, resulting in a re-calculation of each DMEPOS item. This makes it convenient to keep all information current and to perform the study on a semi-annual basis. Many DMEPOS suppliers have software programs that can pull specific data fields, collate the data into a requested format, and dump the information into a report. In these cases, cost reports should be done more frequently than semi-annually simply because the convenience of obtaining this information makes it easier to monitor the cost data.

The final cost information for each DMEPOS item furnished, when considered in aggregate (the total number of each item dispensed on an annual basis), is the cost data that should be used in the final profit or loss determinations. Manufacturer and vendor discounts, such as that given for paying the amount due earlier than specified or those given when purchasing DMEPOS items in bulk, become important when considered on an annual basis. For example, a $2 early-pay discount received for each of 10 items paid early in one month (a total of $20 in savings) can add up to a considerable amount of savings over the space of a year.

The final calculated cost of each DMEPOS item should be organized by CPT or HCPCS Level II code and associated code description (instead of patient name, account number, etc.) for easy interface with reimbursement data. This will facilitate the next step in the financial analysis process—conducting a reimbursement analysis.

DMEPOS Reimbursement Analysis

The reimbursement analysis is the final portion of the financial management analysis needed to determine a particular DMEPOS item's profit or loss margin. Simply stated, the cost data are compared against the reimbursement information and a determination is made.

Reimbursement data for DMEPOS can come from a variety of sources, including the following:
catchment area. Geographical area from which a health care organization draws its members.

CC. Complication or comorbid condition.

CCU. Coronary care unit. Facility dedicated to patients suffering from heart attack, stroke, or other serious cardiopulmonary problems.

CDC. Centers for Disease Control and Prevention.

census. In medical reimbursement, number and demographics of patients or members

Certificate of Medical Necessity. Form required by Medicare to establish the medical necessity of certain DMEPOS. It is completed by both the physician and the supplier, detailing the medical diagnosis and other information specific to the device ordered.

certification. Approval by a payer's case manager to continue care for a given number of days or visits.

CFR. Code of Federal Regulations.

cherry picking. In medical reimbursement, the practice of enrolling only healthy individuals and excluding those with existing problems.

chief complaint. In medical documentation, the presenting problem bringing the patient to the health encounter.

churning. 1) Performance-based reimbursement system emphasizing provider productivity. 2) When a provider sees a patient more than medically necessary with the intent of generating more revenue.

Civilian Health and Medical Program of the Uniformed Services. Federal program that covered the health benefits for families of all uniformed service employees. The program has been replaced by TRICARE.

CLA. Certified laboratory assistant.

claim. Statement of services rendered requesting payment from an insurance company or a government entity.

claim lag. Time incurred between the date of a claim and its submission for payment. "manual Administrative guidelines used by claims processors to adjudicate claims according to company policy and procedure.

claim manual. Administrative guidelines used by claims processors to adjudicate claims according to company policy and procedure.

claims manager. Payer's manager who oversees the employee who processes routine claims.

claims reviewer. Payer employee who reviews claims like an auditor, looking at coding, prior authority, contract violations, etc.

CLIA. Clinical Laboratory Improvement Amendments. Requirements set in 1988, CLIA imposes varying levels of federal regulations on clinical procedures. Few laboratories, including those in physician offices, are exempt. Adopted by Medicare and Medicaid, CLIA regulations redefine laboratory testing in regard to laboratory certification and accreditation, proficiency testing, quality assurance, personnel standards, and program administration.

closed claim. Claim for which all apparent benefits have been paid.

closed panel. Arrangement in which a managed care organization contracts providers on an exclusive basis, restricting the providers from seeing patients enrolled in other payers' plans.

closed treatment. Realignment of a fracture or dislocation without surgically opening the skin to reach the site. Treatment methods employed include with or without manipulation, and with or without traction.

CMA. Certified medical assistant.

CMI. Case mix index. Sum of all DRG relative weights, divided by the number of Medicare cases. A low CMI may denote DRG assignments that do not adequately reflect the resources used to treat Medicare patients.

CMN. Certificate of medical necessity.

CMP. Competitive medical plan. Federal designation allowing plans to obtain eligibility to receive a Medicare risk contract without having to qualify as an HMO.

CMS. Centers for Medicare and Medicaid Services. Federal agency that administers the public health programs.

CMS-1500. Universal form used to file professional claims.

CMT. Certified medical transcriptionist.

COA. Certificate of authority. State license to operate as an HMO.

COB. Coordination of benefits. In health care contracting, method of integrating benefits payable when there is more than one group insurance plan
## Medicare Noncovered Codes

The following is a list of Medicare noncovered HCPCS Level II codes (as indicated in the HCPCS code set master file):

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<td>C2621</td>
<td>Pacemaker, other than single or dual chamber (implantable)</td>
<td>A pacemaker is an electronic system that monitors the electrical impulses of the heart and delivers an electrical charge when necessary to set normal heart rhythms. The term pacemaker that includes cardiac resynchronization devices. This code represents an implantable pacemaker that is neither a single or dual chamber model.</td>
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<td>Infusion pump, nonprogrammable, temporary (implantable)</td>
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<td>Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip</td>
<td>Lay Description</td>
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<td>C2631</td>
<td>Repair device, urinary, incontinence, without sling graft</td>
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<td>C2634-C2643</td>
<td>Brachytherapy source, nonstranded, high activity, iodine-125, greater than 1.01 mCi (NIST), per source</td>
<td>Brachytherapy is a form of radiotherapy in which physicians place the source of irradiation close to the tumor or within a body cavity. Brachytherapy could include placing radioactive sources inside a body cavity (intracavitary brachytherapy) or putting radioactive material directly into body tissue using hollow needles (interstitial brachytherapy). Brachytherapy may be given in addition to external beam radiation or it may be used as the only form of radiotherapy. In some cases, the radioactive sources may be permanently left in place; in other cases, they are removed after a specified time. Placement of radioactive sources may be repeated several times. The isotope gold-198 has a half life of 2.7 days and is used to treat conditions such as prostate cancer. The source is typically a small, radioactive seed or a small, radioactive needle, which is inserted into the tumor. The radiation emitted by the source is absorbed by the tumor and surrounding tissue, killing cancer cells while sparing healthy tissue.</td>
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C2634: Brachytherapy source, nonstranded, high activity, iodine-125, greater than 1.01 mCi (NIST), per source
C2635: Brachytherapy source, nonstranded, high activity, palladium-103, greater than 2.2 mCi (NIST), per source
C2636: Brachytherapy linear source, nonstranded, palladium-103, per 1 mm
C2637: Brachytherapy source, nonstranded, ytterbium-169, per source
C2638: Brachytherapy source, stranded, iodine-125, per source
C2639: Brachytherapy source, nonstranded, iodine-125, per source
C2640: Brachytherapy source, stranded, palladium-103, per source
C2641: Brachytherapy source, nonstranded, palladium-103, per source
C2642: Brachytherapy source, stranded, cesium-131, per source
C2643: Brachytherapy source, nonstranded, cesium-131, per source