



*i*Care Guide for Durable Medical Equipment (DME)
and Disposable Medical Supplies (DMS)
CLAIMS PROCESSING OVERVIEW

Disclaimer:

- This information is provided as a courtesy from *iCare* to assist you with claims submission and billing. This does not replace Forward Health and CMS Guidelines. *iCare* relies upon Forward Health and CMS for payment rules and regulations for claim submission.

DME & DMS – Medical Management

- Prior Authorization is required for select durable medical equipment and supplies
- For detailed procedure code specific information which require prior authorization, please reference the **Prior Authorization Procedure Specific Listing**.
<https://www.icarehealthplan.org/Providers/Authorization.aspx>
- Note: this list is updated on a quarterly basis. Please check the date on the form to ensure you are referencing the most up to date version.

DME & DMS – Medical Management Cont.

- Prior Authorization request form:
<https://www.icarehealthplan.org/Forms/ProviderForms.aspx>
- Please note that supporting clinical documentation is required for all prior authorization requests in order to determine medical necessity. Incomplete prior authorization requests may delay processing. *iCare* will not retro authorize services rendered prior to the determination of a prior authorization

Medicare & Medicaid Coverage

- Medically necessary durable medical equipment a doctor prescribes for use in home. Only the doctor can prescribe medical equipment for a member.
- DME criteria:
 - Durable (long-lasting)
 - Used for a medical reason
 - Not usually useful to someone who isn't sick or injured
 - Used in your home

Medicare Coverage

Medicare coverage includes, but is not limited to:

- Blood sugar monitors
- Blood sugar test strips
- Canes
- Commode chairs
- Continuous passive motion devices
- Continuous Positive Airway Pressure (CPAP) devices
- Crutches
- Hospital beds
- Infusion pumps & supplies
- Lancet devices & lancets
- Nebulizers & nebulizer medications
- Oxygen equipment & accessories
- Patient lifts
- Pressure-reducing beds, mattresses, and mattress overlays
- Suction pumps
- Traction equipment
- Walkers
- Wheelchairs & scooters

Medicaid Coverage

Medicaid coverage includes, but is not limited to:

- Back-up or Secondary Durable Medical Equipment
- Codes
- Compression Garments
- Covered Services and Requirements
- Diabetic Supplies
- HealthCheck "Other Services"
- Home Health Equipment
- Implants
- Mobility Devices and Accessories
- Noncovered Services
- Nursing Home Members and Durable Medical Equipment
- Oxygen and Respiratory Equipment
- Prosthetic Procedures
- Repair of Durable Medical Equipment

DME/DMS Frequently Asked Questions (FAQ)

1. How will Medicare pay for oxygen and oxygen equipment rental?

Answer: Medicare payment for oxygen and oxygen equipment is made on a monthly basis. One bundled monthly payment amount is made for all covered stationary equipment, stationary and portable contents, and all accessories used in conjunction with the oxygen equipment. An add-on payment may also be made for those beneficiaries who require portable oxygen. Per the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), effective January 1, 2009, Medicare payment for oxygen equipment may not continue beyond 36 months of continuous use. After the 36 month rental cap, Medicare will continue to make monthly rental payments for oxygen contents. In addition, payment for in-home maintenance and servicing of supplier-owned oxygen concentrators and trans filling equipment will be made every 6 months, beginning 6 months after the rental cap, for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Payment is made on a monthly basis for oxygen contents for beneficiaries who own liquid or gaseous oxygen equipment.

2. For dual FCP members. Should I receive two prior authorizations for both lines of business (LOB)?

Answer : No, you will only receive one authorization to support both LOBs and date range.

Note: For Traditional Medicare and Medicaid SSI member you will receive two authorizations. One for each line of business and date range.

Clean Claim Guidelines

|  2Care Requirements for Clean Claim (CMS 1500) | | |
|--|--|---|
| Box | Description | Comments |
| 1a | Insured's ID Number | |
| 2 | Patient Name | |
| 3 | Birth Date and Sex | Date of birth must be valid date and not future date |
| 5 | Patient Address | |
| 12 | Patient's or Authorized Person's Signature and Date Signed | Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with "X", Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging |
| 21 | Diagnosis or Nature of Illness | |
| 24a | Dates of Service | Claim must include one detail line, must be a valid date, From date cannot include a future date, cannot have a date span into the future, cannot span a calendar year |
| 24b | Place of Service | Must be 2 characters |
| 24d | Procedures, Services or Supplies | Must be at least 5 characters |
| 24f | Charges | A negative amount will be neglected |
| 24g | Days or Units | |
| 24i/j | Taxonomy code and prefix | Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. |
| 24J (b) | NPI | Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99 |
| 25 | Federal Tax ID Number | Must be 9 numerical characters |
| 28 | Total Charge | Total charges must equal the sum of the line charges |
| 31 | Signature of Physician or Supplier Physician | Not required for SMV claims billed with POS 41,42,99 |
| 33 | Physician/Provider's Name, Billing Address, Zip Code | |
| 33a | Billing Physician/Provider NPI | Must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42,99. The Medicaid provider must be certified as a billing provider. |
| 33b | Taxonomy code and prefix | Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number |

Claims Filing Limits

- Timely filing limits for all providers is 120 days from the date of service, unless otherwise agreed upon and included in the Provider's service agreement with *iCare*.
- Providers are to submit all claims for services rendered where *iCare* Medicare is primary or *iCare* Medicaid is primary according to the terms of the contract. Timely filing limits apply to initial claim submissions, resubmissions and corrected claims.

For More Information:

ForwardHealth Website Link:

<https://www.forwardhealth.wi.gov/WIPortal/>

CMS Website Link: <https://www.cms.gov>

ForwardHealth DME Handbook:

<https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=17&s=9&c=50>

Centers for Medicare and Medicaid Information:

<https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage>

iCare Provider Portal Access

Your time is valuable.

This portal provides you with access to current member eligibility information, claims status and authorization status at your convenience.

A PIN letter containing your unique PIN number is provided by iCare and is required to access the Provider Portal. You can request a PIN number by emailing the completed [Portal Access Request Form](#) to netdev@icare-wi.org.

The [iCare Portal User Guide](#) provides step by step instructions for registration and outlines existing functionalities. If you have any questions, please contact ProviderOutreach@icare-wi.org.

To access the portal, click here: [Provider Portal](#).

iCare Contact Information

Customer Service-Milwaukee Office

(Monday-Friday 8:00-5:00)

Member Local: 414-223-4847

Out Of Area: 1-800-777-4376

Provider Local: 414-231-1029

Out of Area: 1/877-333-6820

Email:

providerservices@icarehealthplan.org

iCare Dane County Office

1-800-777-4376

Inpatient Admissions Notification

414-225-4760

FAX: 414-231-1075

Interdisciplinary Team

414-231-4847

Member Rights Specialist

414-231-1076

Fax: 414-231-1026

Pharmacy

1-800-910-4743

1-877-333-6820

Provider Contracting

414-225-4741

FAX: 414-272-5618