DME POC Reimbursement Policy 0001.0

	Page 1 of 2
Policy Manual: **Reimbursement Policy**	Policy Section: **Durable Medical Equipment (DME)**
Policy Owner by Title: **Manager, Provider Reimbursement**	

POLICY:

Percent of charge for DME Supplies

PURPOSE:

To provide appropriate billing practices for providers regarding procedures not listed on the fee schedule. For DME Suppliers, these supplies are systematically priced at the percent of billed charges per their executed contract. Claims for other Professional providers will pend for manual pre-adjudication review and pricing, using the 55% of charge methodology.

APPLIES TO:

DME procedure codes not found on the standard Fee Schedule table for Regional and BlueChoice Networks.

DEFINITIONS:

Percent of Charge (POC) = the allowed amount is based on a percent of the billed charges submitted by the provider or DME Supplier on the claim.

GENERAL:

When there is no rate available on the Standard Fee Schedule, the code is eligible for reimbursement based on the method provided under Policy Rules.

POLICY RULES:

If there is no fee schedule allowance amount available, reimbursement will be based on the percent of billed charges noted in the executed contract.

- Providers shall list their billed charges at a rate that when the POC is applied, it is equivalent to the manufacturer's invoice cost of the supply plus 10%
- If applicable on the claim the provider must include the description of item, product name, make or model, etc.
- If the above mentioned is not listed on the claim, the provider should supply medical records or manufacturer's invoice along with their claim.

- Providers should follow the HCPCS coding guidelines when billing for supplies in which there are not more appropriate procedure codes available that have established rates on the fee schedule.
- These items may be excluded as a non-covered benefit per the terms of the member's benefit t. Verify availability of benefits by referring to the Member's Benefit Booklet.

RESPONSIBILITY:

A copy of the CareFirst standard fee schedule is available upon on CareFirst Direct for Professional Physician providers or upon request from Provider Relations.

Claims containing miscellaneous/not otherwise specified procedure code(s) may be subject to review prior to approval/adjudication. Paid claims may be subject to retrospective review auditing.

VIOLATIONS:

Procedure codes allowed at a POC are subject to a post-adjudication audit by CareFirst. CareFirst will reach out to the provider, requesting invoices and medical record documentation for verification of charges and appropriate billing. Providers must submit the request information. If the provider does not supply the requested information the claims will be denied and the provider responsible for reimbursing CareFirst for all charges within 30 days of notification. If the total amounts billed are found to be in excess of the policy rules, the provider will be responsible for reimbursing CareFirst for the difference within 30 days of notification. If multiple audits find continued inappropriate billing your participating provider contract may be terminated.

EXCEPTIONS:

LEGAL REFERENCE OR CITATION: