

JOB AID

Processing DME Claims with PAs, Using Local W Codes

Overview

Durable Medical Equipment (DME) providers can use the NCTracks Provider portal to submit claims. This job aid shows DME providers how to complete a claim for products approved on a Prior Approval (PA) request with state/local "W" code(s).

Prior Approval Request with Multiple "W" Codes

When DME providers submit multi-line PA requests with multiple W codes (also known as Local or State code) the W codes must map to the corresponding National Healthcare Common Procedure Coding System (HCPCS) code. NCTracks will map each local W code to the corresponding National HCPCS code. The provider will use the HCPCS code multiple times on a claim for each of the local W codes from the approved PA request. Refer to **Exhibit 3**.

Important: DME Providers must use the local W codes on the PA request – *not* the National HCPCS code.

Important: Only one PA request can be referenced on a claim.

Claims billed with E1399, B9998, K0108, or A9900 HCPCS must map to the corresponding local code from the approved PA. The claim will deny with Edit 1630 when the local code does not map to the corresponding HCPCS code.

Crosswalk of Local Codes to National Codes

The following crosswalk lists local "W" codes and their corresponding National code. Note: W codes may be added or removed from the list as policies and procedures change. These codes are valid as of the date of this publication.

National Code	Local W Codes
E1399	'W4688' 'W4733' 'W4001' 'W4689' ' 'W4002' 'W4690' 'W4016' 'W4691' 'W4047' 'W4695' Note: Local procedure codes W4120, W4153, W4670, and W4678 listed for E1399 are effective for dates of service on or after 10/01/2017
B9998	'W4211' 'W4212'
K0108	'W4005' 'W4139' 'W4713' 'W4722' 'W4117' 'W4140' 'W4714' 'W4723' 'W4118' 'W4141' 'W4715' 'W4717' 'W4119' 'W4143' 'W4716' 'W4718' 'W4130' 'W4144' 'W4145' 'W4719' 'W4131' 'W4133' 'W4150' 'W4152' 'W4132' 'W4155', 'W4142'
A9900	'W4120', 'W4153', 'W4670', 'W4678' Note: Local procedure codes listed for A9900 are effective only for claims with dates of service prior to 10/01/2017

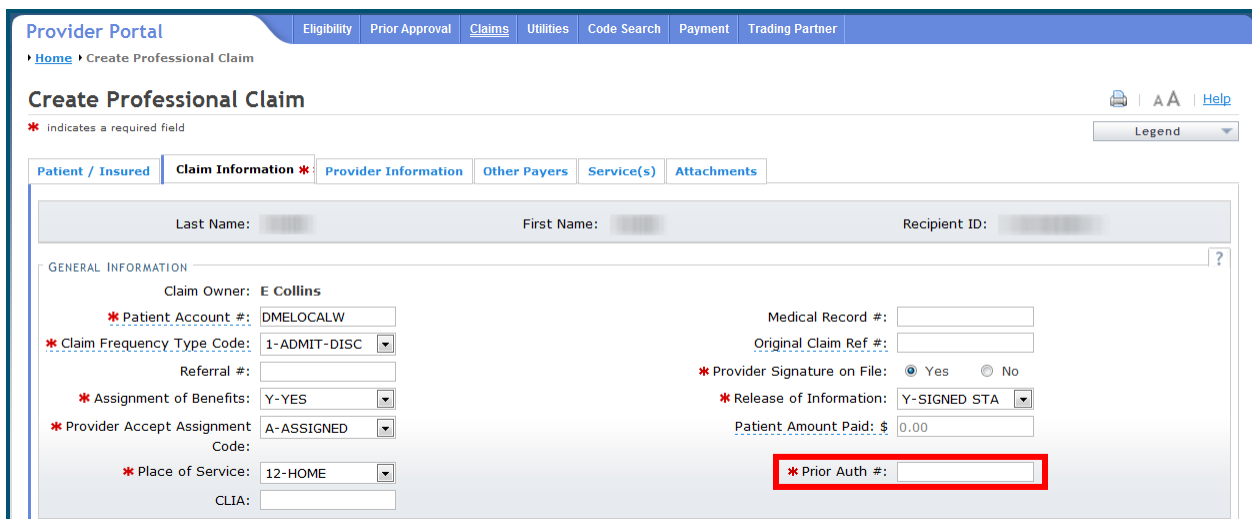
Submitting Claims Using W Codes

The process for submitting claims with Local W codes is the same as submitting claims using HCPCS codes, except for a few differences:

- The Prior Approval number is required on the claim
- There can be only one PA per claim
- On the claim service line, Local W codes must map to the National HCPCS code

Claim Information Screen

On the Claim information screen, when using either the National HCPCS code or Local W code, on a Service(s) line, the **Prior Auth #** field becomes required, as indicated by the red asterisk (*). Enter the Prior Approval number in the **Prior Auth #** field; even though it will not show as being required until the service lines have been entered.



The screenshot shows the 'Create Professional Claim' interface. The 'Claim Information' tab is selected. The 'Prior Auth #' field is highlighted with a red box. The form includes various fields for patient and provider information, including 'Patient Account #', 'Claim Frequency Type Code', 'Assignment of Benefits', 'Provider Accept Assignment Code', 'Place of Service', 'Medical Record #', 'Original Claim Ref #', 'Provider Signature on File', 'Release of Information', and 'Patient Amount Paid'.

Exhibit 1. Claim Information Screen

Service(s) – Service Lines

When using one of the National HCPCS codes (E1399, B9998, K0108, or A9900) on a Service Line, the **Local Procedure Code** drop-down list displays in the Editing Row # section.

The **Local Procedure Code** drop-down list displays valid Local W codes that correspond to the National HCPCS code. There can be only one W code per Service line. When using multiple W codes, the user will need to add additional service lines with the same HCPCS code for each W code.

Exhibit 2. Service Lines

Step	Action
1	The Date(s) of Service From date and To date are required.
2	At least one National HCPCS Code is required, for example, A9900 (MISCELLANEOUS DME SUPPLY, ACCESSORY).
3	The service rendered requires a Modifier . A modifier further defines a HCPCS – for example, NU is New. Enter both code characters in the same field (box).
4	In the Pointer field, enter “1”. Pointers associate the service line item with the diagnosis code row. It goes in the first box from the left.
5	In the Amount field, enter the billed amount.
6	The Quantity represents the number of units for the HCPCS code. Enter the number of units.
7	The Quantity Type identifies the type of measurement used in the Quantity field. For DME, the claims type is UN-Units.
8	If a local W code is being billed, click the Add button to assign the local W code to the National HCPCS code.

Local W Codes Selection

When the user clicks the Add button to add the row line item, the Editing Row #1 section expands. In the Service Line section, the **Local Procedure Code:** field appears and is required. Select the Local Procedure Code drop-down menu and choose the corresponding W code.

The screenshot shows the 'Editing Row #1' form in the MMIS. The 'Service Line' section is highlighted with a red box. A callout box with a red arrow points to the 'Local Procedure Code' dropdown menu, which is open and displaying a list of W codes: W4120, W4153, W4670, and W4678. The callout text reads: 'Local Procedure Code Field is displayed when a National HCPCS Code is entered from E1399, B9989, K0108 and A9900. The local W Codes list displays in the drop-down menu.'

* Date(s) of Service	* Procedure	Modifiers	* Pointers	* Amount	* Quantity	* Quantity Type	Line Item Control Number
07/01/2014-07/01/2014	A9900	NU	1	100.00	1.00	UN-UNITS	

Editing Row #1

Service Line

* Procedure Code: A9900

* Local Procedure Code: [Dropdown Menu]

Description: W4120, W4153, W4670, W4678

* Service Date: [Date Picker] to 07/01/2014

Modifiers: NU

* Amount: \$ 100.00

* Pointers: 1

Line Item Control Number: [Text Field]

General Information

Place of Service: 12-HOME

Referral #: [Text Field]

Immunization Batch #: [Text Field]

CLIA: [Text Field]

Prior Approval #: [Text Field]

Mammography Cert. #: [Text Field]

Sales Tax Amount: \$ [Text Field]

Emergency EPSDT Indicator Family Planning Indicator Copay Exempt

Additional Line Item Information

Would you like to add Additional Line Item Information?

Yes No

Save Service Line Cancel Changes Clear

Exhibit 3. Local Procedure Code

Example of Multiple Service(s) Lines

Remember that each W code must correspond with the National Code and must be on its own Service Lines Editing Row.

Patient / Insured | Claim Information | Provider Information | Other Payers | **Service(s)** | Attachments

Last Name: [REDACTED] First Name: [REDACTED] Recipient ID: [REDACTED]

At least **one** Diagnosis Information record is required in order to create new Service Line records.

DIAGNOSIS INFORMATION

Choose Favorite:

* Code	Description
1. 123	OTH CESTODE INFECT

After a row has been added, click on the row to add / edit more details for an individual row.

SERVICE LINES

* Date(s) of Service	* Procedure	Modifiers	* Pointers	* Amount	* Quantity	* Quantity Type	Line Item Control Number
07/01/2014-07/01/2014	A9900	NU	1	100.00	1.00	UN-UNITS	
07/01/2014-07/01/2014	A9900	NU	1	125.00	1.00	UN-UNITS	
07/01/2014-07/01/2014	E1399	NU	1	135.00	1.00	UN-UNITS	

to

Add Clear

Exhibit 4. Service(s)

Claim Status Details

NCTracks compares the PA # and local codes entered on the claim to the PA database. If there is not a match the claim will deny with Edit Code 01673, If a PA is required, NCTracks will not adjudicate a claim without a Prior Authorization number.



Provider Portal | Eligibility | Prior Approval | **Claims** | Utilities | Code Search | Payment | Trading Partner

Home > Claim Status Request > Claim Status Details-14196000...

Claim Status Details-141960000070000

* indicates a required field

PATIENT
 Name: [REDACTED]
 Recipient ID: [REDACTED]

BILLING PROVIDER
 Provider Name: [REDACTED] NPI: [REDACTED]

PRIMARY STATUS

Payer Claim ID: [141960000070000](#) Account #: DMEWCODE Claim Status Date: 07/15/2014
 Charge Amount: [REDACTED] Paid Amount: \$0.00 Claim Date of Service: 07/01/2014 - 07/01/2014
 Check Date: [REDACTED] Check #: [REDACTED] Adjudication Date: 07/15/2014
 Payment Method: [REDACTED] Prescription Number: [REDACTED]
 Category Code: P0 Category Code Desc: PENDING: ADJUDICATION/DETAILS-THIS IS A GENERIC MESSAGE ABOUT A PENDED CLAIM. A PENDED CLAIM IS ONE FOR WHICH NO REMITTANCE ADVICE HAS BEEN ISSUED, OR ONLY PART OF THE CLAIM HAS BEEN PAID.
 Status Code: 0 Status Code Desc: Cannot provide further status electronically.

Status	Status Description	Procedure Code	Charge Amount	Paid Amount	Quantity	Status Date	Other Status 1	Other Status 2
1	84 Service not authorized.	E1399	[REDACTED]	\$0.00	1.000	07/15/2014	Missing or invalid information.	

1 results (displaying 1-1) [first](#) 1 [last](#)

Exhibit 5. Claim Status Details

Claim Edits

Edit 0351

Claims submitted with a local W code may require manual pricing. Claims will be pended for pricing and providers will see Edit 0351 indicated on their Remittance and Status Report.

Edit 01673

Claims submitted with local codes will deny if an approved PA is not on file or if the local W code on the PA does not match the HCPCS code submitted on the claim. The user will need to re-submit the claim with the appropriate PA number and with the correct National/local W code.

When a wrong PA number is used, the claim will deny with Edit Code 01673. The user will need to re-submit the claim with the appropriate PA number and the correct National code and local W code.