Medicare News

DMERC Region A Service Office • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800 • Phone (570) 735-9445 • www.medicare-link.com

Number 41 • December 1998

Spring '99 Seminars
DMERC 101 & DMERC 201

The Region A DMERC announces its Spring '99 seminar schedule. This Spring we will be offering two seminars; DMERC 101 and DMERC 201. DMERC 101 is geared towards the new biller, and DMERC 201 is for the experienced biller. Topics to be covered in DMERC 101 are: HCFA-1500, Certificates of Medical Necessity (CMNs), Fraud and Abuse, and a DMERC update. DMERC 201 will cover updates on the following: VIPs, HCFA, Medical Policy, and introducing "Life of an Appeal."

DMERC 101 will be covering the ***basic*** billing information that new suppliers and new office staff will need to understand in order to submit claims to the DMERC.

The cost for these seminars are as follows:

DMERC 101	$ 50.00
DMERC 201	$ 50.00
To attend Both	$ 75.00

Seminar Agenda

Registration	8:30 a.m. - 9:00 a.m.
Seminar	9:00 a.m. - 12:00 p.m.
Registration	1:00 p.m. - 1:30 p.m.
Seminar	1:30 p.m. - 4:30 p.m.

Lunch will not be provided.

How to Register

Complete the following registration form and make checks payable to United HealthCare, using the appropriate address as noted on the following page. The registration fees are **non-refundable**.

All attendees must be pre-registered and registrations paid in advance. Due to limited space, registration is on a first come, first served basis. In the event that a particular seminar is filled to capacity, you will be notified by telephone and given the opportunity to make another selection.

Once registration is complete, no changes will be made. Please make your selection very carefully.

Workshop Dates and Locations

April 12
Boston Marriott Newton
2345 Commonwealth Avenue
Newton, MA 02166
617-969-1000

April 14
Holiday Inn by the Bay
88 Spring St.
Portland ME 04101
207-775-2311

April 16
Tara Wayfarer Inn
121 South River Road
Bedford, NH 03110
603-622-3766

April 19
Wyndham Garden LaGuardia
100-15 Ditmars Blvd.
East Elmhurst, NY 11369
718-426-1500

April 20
Ramada Inn Conference Ctr
379 Monmouth St. Exit 8 NJ Tpk
East Windsor, NJ 08520
609-443-8000

April 27
Albany Marriott
189 Wolf Road
Albany, NY 12205
518-458-8444

April 30
Buffalo Marriott Amhearst
1340 Millersport Hwy.
Amhearst, NY 14221
716-689-6900

May 3
Wyndham Garden Airport
One Wyndham Circle
Pittsburgh, PA 15275
412-695-0002

May 5
Philadelphia Airport Marriott
Arrivals Rd
Philadelphia Int'l Airport
Philadelphia, PA 19153
215-492-9000

May 7
Ramada Plaza Hotel
20 Public Square
Wilkes-Barre, PA 18701
717-824-7100

May 11
Hilton Downtown Hartford Hotel
315 Trumball Street
Hartford, CT 06103
860-240-7324

May 13
Resorts International Casino
1133 Boardwalk & North Carolina Ave.
Atlantic City, NJ 08401
609-344-6000

In This Issue

Internet Address
Region A DMERC Office • www.medicare-link.com
HCFA Office • www.hcfa.com

Registrations must be received by the DMERC five business days prior to the date of the seminar you wish to attend. Any registration received after that date will not be accepted and will be returned to the supplier.
Please allow adequate time for mailing.

Mailing Address

Regular Mail	**Overnight Mail**
Attn. Seminar Registration United HealthCare Region A DMERC P.O. Box 6800 Wilkes-Barre, PA 18773-6800	Attn. Seminar Registration United HealthCare Region A DMERC 60 East Main Street Nanticoke, PA 18634

The DMERC reserves the right to cancel any seminar. If this occurs, you will be notified and your registration fee will be refunded.

Note: If you do not receive your confirmation within 5 days of the seminar you have registered for, please call our Professional Relations Unit at 1-717-735-9406

Parking Information

When reserving seminar facilities, we do our best to choose locations with ample, free parking. Unfortunately, cost-free parking is not always available. Please phone the meeting facility for specific information regarding location and possible parking fees

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Registration Form

Please complete a registration form for each person attending.

Company ____________________

Provider Number ________ Submitter Number (Billing Services Only) ____________________

Address ____________________

Phone ____________ Fax ____________________

Location of Workshop ____________________

Amount Enclosed ____________________

Name of Attendee ____________________

Contact Name ____________________

Please check the appropriate box(es) to indicate which workshop(s) you wish to attend.

AM Session 9:00 AM - 12:00 PM	PM Session 1:30 PM - 4:30 PM
❑ DMERC 101 – Basic Billing	❑ DMERC 201 – Advanced Billing

Professional Relations

HCFA Ruling on Delivery of DMEPOS Items Prior to Discharge

The Health Care Financing Administration recently clarified the issue of providing DMEPOS items to beneficiaries prior to discharge to home.

"In some cases it may be appropriate for DMEPOS suppliers to deliver medically necessary equipment to a facility that does not qualify as the patient's home up to two days prior to discharge (to a place that does qualify as a home) for the benefit of the patient for purposes of fitting or training of the patient on its use. However, the equipment must be for subsequent use in the beneficiary's home and no billing may be made for this equipment for days used prior to the date of the patient's discharge from the facility to the home. In such cases, the date of discharge is deemed to be the date of delivery. Suppliers are responsible for any necessary delivery of DMEPOS items and cannot bill the beneficiary or the Medicare program for delivery from the facility to the patient's home. Should a DMEPOS supplier enter into an agreement with such facility to substitute this equipment for DMEPOS required by statute to be provided by the facility, such practice would be considered fraudulent."

Region A DMERC emphasizes the following points with regard to this issue:

- In ALL cases of delivery prior to discharge, the early provision of DMEPOS items is for the purpose of fitting or training of the patient on the item's use, for subsequent use in the patient's home. Items delivered early **solely** for the convenience of the supplier or beneficiary are not allowed.
- There must be no billing for surgical dressings, urological supplies, ostomy supplies or drugs that are used or supplied in the hospital, including items worn home by the patient.
- If the DMEPOS item is delivered to the hospital for use by the beneficiary after discharge to home or residential care facility, the supplier should bill the date of service as the date of discharge to home and should use POS = 12 or 33, as appropriate.
- For prosthetics, orthotics and therapeutic shoes for diabetics delivered to a beneficiary being transferred (discharged) to a skilled nursing facility or nursing facility after discharge from the hospital, the supplier should bill the date of service as the date of transfer (discharge) to the SNF / NF and should use POS = 31 or 32 as appropriate.
- If a DMEPOS item is delivered to a beneficiary's home in anticipation of discharge from a hospital or SNF / NF, the supplier should bill the date of service as the date of discharge from the facility.

In all cases of early delivery of DMEPOS items, the delivery date may only be made within two (2) days of the anticipated discharge date AND no billing may be made for those days of use prior to the date of discharge.

HCFA Medicare Supplier Standards*

1. A supplier will fill orders from its own inventory or inventory of other companies with which it has contracts to fill such orders; or fabricates or fits such items for sale from supplies it buys under a contract.
2. A supplier is responsible to oversee delivery of items that the supplier ordered for the beneficiary. The supplier is also responsible to assure delivery of large items to the beneficiary.
3. A supplier honors all warranties, express or implied, under applicable State law.
4. A supplier will answer questions or complaints a beneficiary has about an item or use of an item that is sold or rented to the beneficiary. If the beneficiary has questions about Medicare, the supplier will refer the beneficiary to the appropriate carrier.
5. A supplier maintains and repairs directly, or through a service contract with another Company, items it rents to a beneficiary.
6. A supplier accepts returns of substandard (less than full quality for a particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and / or sold) from the beneficiary.
7. A supplier discloses consumer information to each Medicare customer. This consists of a copy of these supplier standards to which it must conform.
8. A supplier complies with the disclosure provisions in Title XI of the Social Security Act, Section 1124A(a).
9. A supplier must comply with all State and Federal licensure and regulatory requirements.
10. A supplier must maintain a physical facility on an appropriate site.
11. A supplier must have proof of appropriate liability insurance.

*** As of 9/98; subject to revision**

DMERC Hearing Suggestions

Hearing Requests

When requesting hearings that involve accounting overpayment determinations, please include a copy of your overpayment letter. This letter will aid us in the preparation of the hearing case.

If these letters are not included, this may result in an unnecessary delay in preparing the hearing file.

New Codes for Amphotericin B

A new code has been established for any formulation of amphotericin B lipid complex. The new code:

J0286 Injection, amphotericin B, any lipid formulation, 50 mg

is effective for claims with dates of service on or after January 1, 1999. Currently, there are 3 liposomal preparations of amphotericin B being manufactured. They are:

Abelcet
Amphotec
Ambisome

If a manufacturer or supplier thinks that another product meets the definition of this code, they must contact the Statistical Analysis DME Regional Carrier (SADMERC) for a written coding determination.

Liposomal amphotericin B is covered for patients who have suffered some significant toxicity that would preclude the use of standard amphotericin B and are unable to complete their course of therapy without the liposomal form. Also, the liposomal form is covered for patients who have impaired hepatic function. Claims for liposomal amphotericin B will be considered for coverage according to the payment and coverage rules outlined in the "External Infusion Pumps" policy in the *Region A DMERC Supplier Manual*. In addition to the documentation requirements outlined in this policy, initial claims for J0286 must be submitted with a statement obtained by the supplier from the physician indicating why the liposomal form of amphotericin B is needed for a particular patient. If the documentation is not submitted or does not support the medical necessity of the need for this form of the drug for the particular patient, coverage will be based on the least costly medically appropriate alternative, standard amphotericin B (J0285).

A new code has also been established for the standard form of amphotericin B. K0453 was the appropriate code used for billing standard amphotericin B. Effective for claims with dates of service on or after January 1, 1999, a new J code has been established:

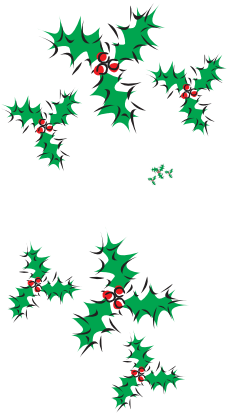
J0285 Injection, amphotericin B, up to 50 mg

Claims for code K0453 will not be valid for claim submission to the DMERC if both: (a) the date of service is on or after January 1, 1999 **and** (b) the claim is received on or after April 1, 1999.

Peak Flow Meters

HCPCS Code A4614, Peak flow meter, hand held, has been established effective for dates of service on or after January 1, 1999.

Peak flow meters are covered for the self-monitoring of patients with pure asthma (ICD-9 493.00 - 493.11), when they are used as part of a comprehensive asthma management program. Insufficient evidence exists to demonstrate that there is a benefit to the use of peak flow meters in patients with other respiratory diseases, e.g., COPD, bronchitis, emphysema, etc. All of the patient's pulmonary ICD-9 diagnosis must be included on claims submitted for A4614. Claims for A4614 with diagnoses other than asthma will be denied as not medically necessary.



New Code for Heat and Moisture Exchanger for Use With Invasive Mechanical Ventilation

Effective for claims with dates of service on or after January 1, 1999, a new code has been established for a disposable moisture exchanger used with invasive mechanical ventilation. The new code is:

A4483 Moisture exchanger, disposable, for use with invasive mechanical ventilation

A4483 is used for patients on an invasive mechanical ventilator (E0450) in the home setting. E0450 is a rental item, therefore, A4483 will be denied as not separately payable.

New Code for Daclizumab

A new code has been established for daclizumab, trade name: Zenapax. The new code effective for dates of service on or after January 1, 1999 is:

J7513 Daclizumab, parenteral, 25 mg

is a monoclonal antibody that is used as part of an immunosup- pressive drug regime following organ transplant. Daclizumab is administered intraveneously. The safety of intraveneous administration of monoclonal antibodies in the home setting is not established. Therefore, daclizumab will be denied as not medically necessary in the home.

For more information on Coverage and Payment Rules and Documentation as they relate to immunosuppressive drugs, please see the policy "Immunosuppressive Drugs" in the *Region A DMERC Supplier Manual.*

Custom Breast Prosthesis

A new code has been established for a breast prosthesis:

L8035 Custom breast prosthesis, post mastectomy, molded to patient model.

This code is effective for claims with dates of service on or after January 1, 1999.

A custom fabricated prosthesis is one which is individually made for a specific patient starting with basic materials. A molded-to-patient-model breast prosthesis is a particular type of custom fabricated prosthesis in which an impression is made of the chest wall and this impression is then used to make a positive model of the chest wall. The prosthesis is then molded on this positive model.

Compared to a prefabricated silicone breast prosthesis (L8030), the additional features of a custom fabricated prosthesis are not medically necessary. Therefore, if a L8035 breast prosthesis is provided to a patient who has had a mastectomy, payment will be based on the allowance for the least costly medically appropriate alternative, L8030.

Cervical Cap - Non-Covered

The cervical cap is a thimble-shaped latex device that covers the cervix and is used as an effective barrier method of contraception. A new code, A4261 - Cervical cap for contraceptive use, has been established for claims with dates of service on or after January 1, 1999. Claims submitted to Medicare will be denied as non-covered.

J0275 - Alprostadily Urethral Suppository

Alprostadily urethral suppository is a self-administered transurethral system used for the delivery of alprostadil to the male urethra. It is indicated for the treatment of erectile dysfunction. Effective for claims with dates of service on or after January 1, 1999, a new code has been established to describe this item:

J0275 Alprostadil, urethral suppository, administered under direct physician supervision, excludes self administration

This drug was previously identified by code Q0182 for claims with dates of service on or after July 1, 1998. Claims for alprostadil urethral suppository are submitted to the local carrier for processing.

New Code for Morphine Sulfate

Effective for claims with dates of service on or after January 1, 1999, a new code has been developed for morphine sulfate. The new code is:

J2271 Injection, morphine sulfate, 100 mg

Coverage for morphine sulfate is dependent upon the use of an external infusion pump when used in the treatment of intractable pain caused by cancer. Currently, there are 2 codes (J2270 and J2275) that are valid and remain in effect to bill for morphine in 10 mg increments. In order to facilitate processing of claims for this drug for patients requiring higher doses, a new code J2271 was created.

For additional information, please refer to the "External Infusion Pump" policy in the *Region A Supplier Manual.*

E0785 - Local Carrier Jurisdiction

A new code has been established for implantable intraspinal catheters used with implantable infusion pumps effective for claims with dates of service on or after January 1, 1999. The new code is:

E0785 Inplantable intraspinal epidural/intrathecal catheter used with implantable infusion pump, replacement

The DMERC does not process claims for implantable infusion pumps or medications and supplies used in conjunction with an implantable infusion pump. Claims for these items must be submitted to the local carrier.

Prosthetics - Documentation Requirement Reminder

When submitting claims to the DMERC, the billed code for knee, foot, and ankle prosthetic components must be submitted with modifiers K0 - K4. The modifiers are required to indicate the functional level of beneficiaries for coverage purposes for the following HCPCS codes:

- L5610 - L5616
- L5710 - L5780
- L5810 - L5840
- L5970 - L5981
- L5982 - L5986

The presence of a modifier is not sufficient by itself to document the functional level. A detailed narrative description of the patients' functional ability must be clearly documented in the prosthetist's records and be available to the DMERC upon request.

Expansion of Coverage - Oral Anti-Cancer Drugs

Medicare has expanded coverage of certain oral anti-cancer drugs to include FDA approved oral anti-cancer prodrugs effective for claims with dates of service on or after January 1, 1999. Prodrugs have the same active ingredients in the body as injectable anti-cancer drugs. For coverage under the oral anti-cancer drug benefit, an oral drug may have a different chemical composition from an injectable drug at the outset, but after metabolism, it must have the same active chemical composition as the injectable drug.

At present, the oral anti-cancer drug benefit includes coverage for cyclophosphamide, etopside, methotrexate, and melphalan. This benefit is being expanded to include a 5-FU prodrug, capecitabine, trade name: Xeloda manufactured by Roche.

Claims for oral anti-cancer drugs and prodrugs are billed to the DMERC on form HCFA-1500 or its electronic equivalent using the appropriate National Drug Code (NDC). In addition to the NDC numbers listed in the **Appendices section of the Region A DMERC Supplier Manual for Oral Anti-Cancer Drugs**, the following NDC numbers have also been approved for coverage:

0004-1100-22	Capecitabine, 150mg, oral, 1 tab per unit
0004-1100-51	Capecitabine, 150mg, oral, 1 tab per unit
0004-1100-13	Capecitabine, 150mg, oral, 1 tab per unit
0004-1101-51	Capecitabine, 500mg, oral, 1 tab per unit
0004-1101-16	Capecitabine, 500mg, oral, 1 tab per unit
0004-1101-13	Capecitabine, 500mg, oral, 1 tab per unit

Claims for specific oral anti-cancer prodrugs must include a cancer diagnosis on the claim form. The physician / supplier must have a valid license to dispense prescription drugs.

Tracheostoma Filters

Tracheostoma filters are devices used with a tracheostomy tube or over an open tracheostomy stoma. Commonly called the "artificial nose," these devices provide for the humidification and air filtration needs of the tracheostomized patient. Claims for tracheostoma filters must be billed using code A4481- Tracheostoma filter, any type, any size, each. This code became effective for claims with dates of service on or after January 1, 1997.

Examples of products that would meet the definition of this code include, but are not limited to, The Provox Stomafilter, all types; Gibeck Inc.- StomVent; Dean Rosecrans-Foam filters; EZ Speech Inc.- Stoma foam filters; Bruce-Foam stoma filters; In Health Tech-Foam discs.

A4481 is covered for a patient who has had a tracheostomy. More than one per day of A4481 would rarely be medically necessary unless documentation was submitted with the claim to justify the greater amount in the individual case.

Oral Appliances for OSA

Oral appliances used to treat obstructive sleep apnea (OSA) will be considered for coverage if they meet the general coverage requirements for durable medical equipment (DME) and are determined to be reasonable and necessary in the treatment of the specific patient. Claims for these items must be submitted to the DMERC using code E1399 - Durable Medical Equipment, miscellaneous. Claims must be accompanied by the following information:

1. The name and manufacturer of the specific device that was provided.

2. A statement of the estimated appliance useful lifetime before replacement is necessary if the patient uses it daily.

3. Documentation from the treating physician stating the diagnosis, what other therapy had been tried or considered, and why the oral appliance is being ordered.

4. A copy of the polysomnogram report which documents the patient's sleep disorder and a copy of a sleep study report which documents improvements with the use of the oral appliance.

Any other information that addresses the medical necessity of the device for the specific patient may also be included with the claim. Claims without the required documentation will be denied as not medically necessary.

Oral appliances used to treat snoring without a diagnosis of OSA are coded E1399 and will be denied as not medically necessary.

Oral appliances for other non-dental conditions would be coded E1399. Claims must be accompanied by information similar to 1, 2, and 3 above, as well as literature references documenting the effectiveness of this type device for the diagnosis for which it was prescribed. These claims will be evaluated on a case-by-case basis.

Oral occlusal appliances used to treat temporomandibular joint (TMJ) disorders are coded D7880 - Occlusal orthotic appliance. These devices are considered dental-related items, and therefore, non-covered by Medicare. If a supplier wants to submit a claim for a TMJ device, that claim would have to be sent to the local carrier, not the DMERC, because local carriers have jurisdiction for processing D codes.

Coding of Seat Lift Mechanisms

When providing a seat lift mechanism which is incorporated into a chair as a complete unit at the time of purchase, suppliers must bill the item using the established HCPCS code E0627 - seat lift mechanism incorporated into a combination lift-chair mechanism. In this situation, the supplier may bill the seat lift mechanism using E0627 and A9270 for the chair. If, however, the seat lift mechanism, electric or non-electric, is supplied as an individual unit to be incorporated into a chair that a patient owns, the supplier must bill using the appropriate code for the seat lift mechanism for use with patient owned furniture, E0628 or E0629.

Coverage is limited to the seat lift mechanisms even if it is incorporated into a chair. The chair is a non-covered item and will be denied when billed separately.

For additional information on coverage, payment and documentation for seat lifts refer to the "Seat Lift Mechanisms" policy in the *Region A DMERC Supplier Manual*.

New Code for Percutaneous Catheter/ Tube Anchoring Device

Effective for claims with dates of service on or after January 1, 1999, a new code has been established for billing an anchoring device for percutaneous tubes / catheters. The new code is:

A5200 Percutaneous catheter/tube anchoring device, adhesive skin attachment

A5200 is covered and separately payable when it is used to anchor a covered suprapubic tube or nephrostomy tube. Coverage for A5200 is dependent on the documentation requirements outlined in the "Urological Supplies Policy" published in the *Region A DMERC Supplier Manual*. When billing for A5200, the ZX modifier must be added to the claim when the order from the treating physician indicates permanent urinary incontinence or permanent urinary retention and the item is used with a urinary catheter. If these requirements are not met, the ZX modifier may not be used, but the supplier can submit additional information with the claim to justify coverage.

Adhesive catheter anchoring devices for indwelling urethral catheters and catheter leg straps are billed using codes K0407 and K0408, respectively (refer to the *Region A DMERC Supplier Manual* for additional information). Payment for A5200 will be based on the allowance for the least costly medically appropriate alternative, K0407.

A5200 should not be billed separately and is not paid in addition to the supplies for enteral nutrition or external infusion pumps. Payment for a catheter / tube anchoring device is considered included in the allowance for enteral feeding supply kits (B4034 - B4036) or supplies for maintenance of a drug infusion catheter (A4221), respectively.

1999 Deleted Codes

The following HCPCS codes are deleted effective for dates of service on and after January 1, 1999.

K0453 Injection, amphotericin B, 50 mg

L4310 Multi-podus or equal orthotic preparatory management system for lower extremities

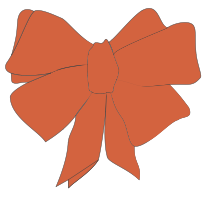
L4320 Addition to multi-podus (or equal) orthotic preparatory management system for lower extremities, flexible foot positioner with soft interface for AFO, with velcro closure

L4390 Replace soft interface material, multi-podus type splint

Instead, the following codes should be used for billing:

Code used for dates of service before January 1, 1999:	Code used for dates of service on and after January 1, 1999
K0453	J0285
L4310	L4396
L4320	L4392
L4390	L4392

There is a 3-month grace period for discontinued codes. This grace period applies to claims received by the DMERC before April 1, 1999 which include 1998 discontinued codes for dates of service January 1, 1999 to March 31, 1999.



Reminder: Fee Schedule Changes

As mandated by the Balanced Budget Act of 1997, fee schedule changes for durable medical equipment will change as follows:

- For 1999, the fee schedule amounts for oxygen and oxygen equipment will be reduced by an additional 5 percent.
- The covered item update for prosthetics and orthotics will be 1 percent for each of the years 1998 through 2002.
- The covered item update for durable medical equipment (DME) and surgical dressings will be 0 percent for each of the years 1998 through 2002.

1999 HCPCS Codes

Chapter 5 of the *Region A DMERC Supplier Manual* has been updated to include HCPCS codes that have been added, deleted, or modified effective for dates of service on or after January 1, 1999. A HCPCS Index has been added at the end of the chapter for easy reference.

The Classification listings contained in the Appendices section of the manual have also been updated to include current coding recommendations for specific products. This section contains listings for the following items:

- Enteral Nutrients
- Group I Support Surfaces
- Group II Support Surfaces
- Lymphedema Pumps
- Nebulizers
- Oral Anti-Cancer Drugs
- Surgical Dressings
- Wheelchairs

For products not included on these lists, the supplier or manufacturer may contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for coding verification. The SADMERC operates a Help Line at (803) 736-6809 from 9 AM - 12 noon, and 1 PM - 4PM, Monday through Friday.

Tracheostomy Care Supplies - ICD-9 Requirement

Tracheostomy care supplies are covered for patients following an open surgical tracheostomy which has been open or is expected to remain open for at least 3 months.

Effective for claims with dates of service on or after March 1, 1999, claims submitted for a patient with a tracheostomy for the following tracheostomy care supplies HCPCS codes:

A4622, A4623, A4625, A4626
A4629, A4481

must include the ICD-9 code V44.0, V55.0, or 519.00 - 519.09. Claims submitted without this documentation will be denied as not medically necessary unless additional medical documentation is provided.

Please refer to the "Tracheostomy Care Supplies" policy in the *Region A DMERC Supplier Manual* for further information.

New Code for Post Mastectomy Undergarment

A new code has been established for billing post mastectomy undergarments to the DMERC. The new code is:

L8015 External Breast Prosthesis Garment, with mastectomy form, post mastectomy

The code describes a camisole type garment with polyester fill. This item is covered for use in the post operative period prior to the permanent breast prosthesis or as an alternative to a mastectomy bra (L8000) and breast prosthesis (L8020 - L8039). This code is effective for claims with dates of service on or after January 1, 1999.

For additional information and documentation requirements, please refer to the "External Breast Prosthesis" policy in the *Region A Supplier Manual.*

Billing

Billing Reminders - Vision Claims

The following are some billing reminders for submitting vision claims. Deluxe frames are billed using 2 lines on the claim form. Progressive lenses are also billed using 2 lines on the claim form. An explanation and example of the correct billing procedure follows.

Deluxe Frames

Deluxe frames are billed using code V2020, on the first line, for the cost of the standard frame, and V2025, on the second line, for the difference between the charges for the deluxe frame and the standard frame.

Ex: When the beneficiary chooses a pair of Deluxe frames with a cost of $ 95.00, the claim should be submitted using V2020 (standard frame), on the first line, for the cost of the standard frame, and V2025 (deluxe frame), on the second line, for the difference between the standard frame and the deluxe frame.

(95.00 - 44.48 = 50.37)

A Date of Service	B Place of Service	C	D Procedure Code, Modifiers	E	F Charges	G Days or Units
09/01/1996	12		V2020		$ 44.83	1
09/01/1996	12		V2025		$ 50.37	1

Progressive Lenses

Progressive lenses are billed using 2 lines. The first line would have the appropriate code for the standard bifocal (V2200 through V2299), or trifocal (V2300 through V2399), and the second line would have V2781 for the difference between the progressive lens and the standard bifocal/trifocal.

Ex: When the beneficiary chooses a progressive lens with a cost of $ 100.00 per lens, the claim should be submitted using V2200 (sphere, bifocal, plano to plus or minus 4.00D, per lens), on the first line, for the cost of the bifocal and V2781 (progressive lens, per lens), on the second line, for the difference between the standard bifocal and the progressive lens.

100.00 - 47.37 = 52.63)

A Date of Service	B Place of Service	C	D Procedure Code, Modifiers	E	F Charges	G Days or Units
09/01/1996	12		V2200RTLT		$ 47.37 *	1 *
09/01/1996	12		V2781		$ 52.63 *	1 *

* Please note - if you are billing for 2 lenses the charge submitted and the units should reflect this:

charges	V2200	$ 94.74	units	2
	V2781	$ 105.26		

Also please note, the modifier showing right (RT) and / or left (LT) should also be included with the procedure code.

If you are billing the right eye for a bifocal with V2200 (sphere, bifocal, to plus or minus 4.00D, per lens) and the left eye for a different lens V2309 (spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens) the correct procedure codes and modifiers would be: V2200RT V2309LT

The complete claim form for a deluxe pair of frames with progressive lenses would be submitted as follows:

A Date of Service	B Place of Service	C	D Procedure Code, Modifiers	E	F Charges	G Days or Units
09 / 01 / 1996	12		V2020		$ 44.83	1
09 / 01 / 1996	12		V2025		$ 50.37	1
09 / 01 / 1996	12		V2200RTLT		$ 94.74	2
09 / 01 / 1996	12		V2781RTLT		$105.25	2

Also, please note for claims with dates of service on or after March 1, 1998 the following items are reimbursed by Medicare if they are specifically ordered by the treating physician and are not only a patient preference. The ZX modifier must be used only if the requirement is met. The documentation supporting the medical necessity of these items must be kept on file in the providers records:

V2740 - V2744	Tints	V2755	UV coating
V2750	Anti-reflective coating	V2780	Oversized lenses

Please understand V2760, scratch resistance coating, is not medically necessary and therefore is not covered. Refer to page 16.7-5 through 16.7-6 in the *Region A DMERC Medicare Supplier Manual* for complete Coverage and Payment rules.

Also, some of the recent errors the DMERC has noticed in the submission of claims is the lack of, or incorrect, information in the following sections of the HCFA-1500 claim form:

Block 11 If Medicare is the primary insurance, the word **NONE** should be entered.

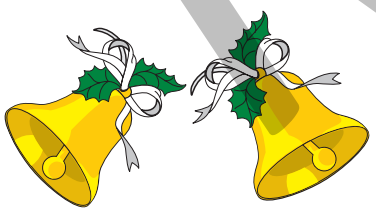
Block 17 The referring Physician's name.

Block 17A The referring Physician's UPIN number.

Block 21 ICD-9-CM diagnosis code must be used for billing lenses:
V43.1 Pseudophakia (implant)
379.31 Aphakia (no implant)
743.35 Congenital Aphakia

Block 32 If the place of service is other than 12 (home) the name and address of the facility where the services were rendered should be entered. Otherwise this can be left blank.

Block 33 Provider number must be on the claim form in order to process the claim. This is also known as the 10 digit NSC number that was issued by the National Supplier Clearinghouse (NSC).



EDI

Elimination of Accelerate 5.25" Diskettes

Beginning January 1, 1999, the Region A DMERC will no longer provide or support our Accelerate software on 5.25" diskette. If you wish to receive any updates to the software after this date you will need a 3.5" disk drive.

Addenda Required

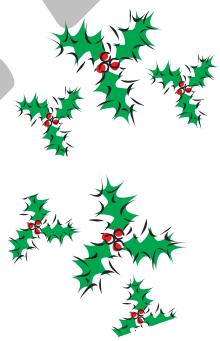
Effective July 6, 1996, the Region A DMERC began requiring a signed addendum from all submitters that wish to receive On-Line Claim Status, Electronic Remittance Notices, and Eligibility. You may request a copy of these addenda from the EDI Help Desk or download copies from our web page.

New Claim Status Inquiry System

With our conversion to the new VMS system, we are converting to a new claim status inquiry system also known as VPIQ. This system offers more than the previous claim status system. With VPIQ you will be able to search for a HICN or date of service for your provider number and you can receive complete listings of pending claims as well as a summary of the number of claims pending in the processing system. If you are a "Participating Provider," the VPIQ system offers electronic eligibility online. To be setup for VPIQ, contact the EDI Help Desk to receive an addendum for you to authorize the setup of these options.

BBS Toll Free Line Termination

Effective October 1, 1998, HCFA will no longer fund toll-free EDI transmission lines for participating physicians and suppliers. On October 1, 1998, the Region A DMERC will discontinue the use of toll-free EDI lines for claim submission to our BBS. All electronic submitters will now dial our current toll BBS number of 717-735-9515.



1999 Fee Schedule

The Region A DMERC will not be providing complimentary copies of the 1999 fee schedule, per HCFA instruction. You may access the fee schedule data on our bulletin board or website at *www.medicare-link.com*.

The cost for the hardcopy is $15.00

If you would like a copy, complete the following form and make checks payable to United HealthCare at:

United HealthCare
Attention: Professional Relations
P.O. Box 6800
Wilkes-Barre, PA 18773

Company _____ Provider Number _____

Contact Name _____ Address _____

Phone _____ Fax _____ Number of copies _____ Amount Enclosed _____

Supplier Notices

Elimination of Funding Toll-Free Lines for Participating Physicians and Suppliers

Supplier Notice 98-17
September 2, 1998

As part of incentives to increase participation, the Health Care Financing Administration (HCFA) made available toll-free lines to providers for electronic media claims (EMC) transmission. Unfortunately, because of budget constraints, HCFA can no longer continue this incentive. Effective January 1, 1999, we can no longer provide EMC toll-free telephone service to participating physicians and suppliers. As your Medicare carrier, it is extremely important for us to assist you during this transition in order to avoid any interruption in your submission of electronic claims. It is our goal to help you obtain quality, affordable long distance telephone service. While the decision on which company to select is yours, there are a variety of charge features from which to choose. Please be aware that we cannot pay any long distance service to deliver your electronic claims submissions to us. As your Medicare carrier, we must also remind you that, at this time, we cannot accept electronic claims via the Internet as this would risk the privacy of Medicare beneficiary data. However, HCFA is exploring the Internet option.

EMC Reject Report - Update

Supplier Notice 98-18
September 11, 1998

The CMN Reject Report is sent to all EDI submitters when CMNs associated with accepted EMC claims are rejected by the VMS / VIPS system. The following is a new Reject Code and Definition you may see on your report.

3052 - CMN CLSD - NON REV

When revisions to closed CMNs are received, the system will reject the CMN because of one of the following reasons:

- Discontinued
- Maintenance Only
- Capped Rental - Purchased 13th Month
- Reasonable Purchase Price Reached
- Recertification Not Received (PEN / Oxygen)

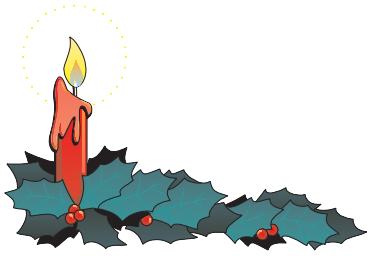
All questions regarding CMN rejects should be directed to our Services Department at (717) 735-9445.

Team Processing

Supplier Notice 98-19
September 11, 1998

In July 1998, the Region A DMERC began using the VIPS standard system to process claims. Since the transition, we have been using a feature that is available in the VIPs system that allows similar work to be moved into manageable volumes for quicker and more consistent claim adjudication. With this process, claims are sorted by HCPCS codes and assigned to specific teams for processing. This team processing capability enhances our ability to develop edits, increase automation and improve processing consistency.

The process results in one check being issued per HCPCS category being processed. Previously, we issued a single check or remittance notice related to multiple types of services. While consistency advantages are clearly available with this method, we realize it does produce more transactions for you to handle. Therefore, we are currently exploring the feasibility of reducing the number of transactions, while retaining the advantages gained by using this approach.



VIPS Update

Supplier Notice 98-20
September 11, 1998

The Region A DMERC transitioned to the VIPS Medicare processing system on July 1, 1998. While the transition was successful, we have experienced some unexpected problems. The following information is intended to keep you informed of areas that may affect you.

Customer Service

You may have experienced problems reaching us through our provider customer service lines. Staff training activities are progressing on schedule to restore our service to levels that both you and we expect, as quickly as possible. We apologize for any inconvenience you may have experienced.

To help minimize any long-distance telephone costs you may incur due to delays resulting from the transition, the Region A DMERC has installed a toll-free number to our Provider Services Department. This toll-free number will become available, effective immediately, and will be operational between 8 a.m. to 4 p.m., Monday through Friday. To use the toll-free number, please call:

1-877-482-9056

We will continue to offer this toll-free number until service levels return to normal.

While the toll-free number will be available, suppliers may continue to experience delays in accessing the Automated Response Unit (ARU) and Customer Service Representatives (CSRs).

Paper Claims

Suppliers who submit paper claims have expressed concern that their claims cannot be identified by the CSR. Although claims have been received, if they have not been processed, they cannot be viewed by the CSR on the system. This is not a change from the previous system.

To ensure that your claims were processed as quickly as possibly during this transition period, the Region A DMERC has contracted additional resources to enter paper claims. While the processing of claims may experience a slight delay during this initial period of the transition, every effort is being made to remain within the 30-day processing period. This is our typical standard. Further information on processing time requirements can be found in Provider Notice 96-21, "Payment Floor."

Duplicate Denials

Several suppliers have experienced an increase in duplicate claim denials. This problem has been identified, and steps are being taken to correct this situation. We will keep you informed of future developments.

[*Refer to Supplier Notice 98-29*]

Modifiers

Supplier Notice 98-16, dated September 1, 1998, addressed the use of HCPCS modifiers. Please refer to this notice; it contains examples of correct modifier usage. Effective October 1, 1998, claims with missing or invalid modifiers will be denied as unprocessable in accordance with the HCFA return / reject mandate.

Crossover Claims

Suppliers have expressed concern that they are experiencing difficulty with crossover claims. We have determined that some claims for the months of July and August did not successfully crossover to secondary insurers. We are continuing to research this issue and will keep you informed of future developments.

Reviews

Completion of reviews is currently exceeding the standard of 45 days. It is anticipated that, within 12 weeks, reviews will be completed within the norm of 45 days or less.

The Region A DMERC recognizes the importance of providing quality customer service to meet the expectations of our customers. We will continue to keep you informed of all future developments as we respond to these transition-related issues.

Oxygen Billing Reminder

Supplier Notice 98-21
October 15, 1998

When billing the Region A DMERC for oxygen or oxygen equipment, the correct HCPCS modifiers must be billed with each HCPCS code to properly represent the equipment or supply that was delivered.

- Claims billed for stationary oxygen equipment with a liter flow less than 1 LPM must be billed with a "QE" modifier.
- Claims billed for stationary oxygen equipment, with a liter flow greater than 4 LPM, must have the "QG" modifier added to the stationary code if *no* portable oxygen is prescribed.
- Claims billed for both stationary and portable oxygen equipment, with a liter flow greater than 4 LPM, must have the "QF" modifier added to the stationary code. The "QF" modifier should not be added to the portable oxygen code.

Examples:

E1400QE	Liter flow < 1 LPM
E0439QG	No portable oxygen prescribed
E1403QG	No portable oxygen prescribed
E0439QF E0434	Portable oxygen prescribed
E1404QF E0431	Portable oxygen prescribed

- When billing for an oxygen concentrator when the liter flow is greater than 4 LPM, the appropriate procedure code must be billed to signify an oxygen concentrator which has the capability to produce a liter flow greater than 4 LPM.

Examples:

Code - Description - Validity

E1400QG
Maximum flow rate ≤ 2 LPM;
Not Valid

E1401QG
Maximum flow rate ≤ 3 LPM;
Not Valid

E1402QG
Maximum flow rate ≤ 4 LPM;
Not Valid

E1403QG
Maximum flow rate ≥ 4 LPM ≤ 5 LPM
VALID

E1404QF, E0431
Maximum flow rate > 5 LPM
VALID

This Notice is in addition to, not a substitute for, Supplier Notice 98-16, issued September 1, 1998. The purpose of this notice is to serve as a reminder for the correct billing procedures for oxygen and oxygen equipment.

Claims with missing or invalid modifiers will continue to be denied as unprocessable in accordance with HCFA return/reject mandate for all claims received on or after October 1, 1998.

HCPCS Modifiers Reminder

Supplier Notice 98-22
October 15, 1998

This release is a reminder of information regarding HCPCs modifiers that was first published in the December 1995 *Region A DMERC Newsletter* (page 24), and again published as Supplier Notice 98-16:

- Claims with missing or invalid modifiers will be denied as unprocessable in accordance with HCFA return/reject mandate. This will affect all claims received on or after October 1, 1998.
- In addition, claims will be denied under the return/reject mandate when unnecessary modifiers are used.
- Claims that are denied under the return/reject mandate must be resubmitted with complete valid information for appropriate claim adjudication.

Please make note of this information to avoid any unnecessary claim denials.

EDI Phone Number Reminder

Supplier Notice 98-23
October 15, 1998

In January 1997, the EDI Help Desk changed their phone number to **717-735-9429**. This is the only number to be used. In the past, the calls were being forwarded, but this has been discontinued as of September 1, 1998.

It has come to our attention that some software vendors may not have received the updated phone number and may still be producing material for you with the old EDI Help Desk phone numbers. Please check any material produced by your software vendor for an incorrect number and have corrections made immediately.

If you continue to dial the old phone numbers you will not reach the EDI Help Desk and your call will not be forwarded.

DMERC Communication Suggestions

Supplier Notice 98-24
October 23, 1998

* *We are replacing Notice 98-24 with Notice 98-39, which we have recently published because of the importance of this issue.*

Inquiries Sent via Internet

Supplier Notice 98-39
December 10, 1998

As Internet usage increases, we have seen that certain confidential beneficiary and provider information is being sent over the Internet.

Providers should not include Medicare numbers, Social Security

numbers, personal medical information, NSC numbers, or other confidential items regarding the Medicare beneficiary in the e-mail inquiry.

We appreciate your use of the Internet whenever possible, but HCFA requirements preclude its use where any confidential information is involved.

Certificate of Medical Necessity Completion

Supplier Notice 98-25
November 6, 1998

The Region A DMERC developed the attached memo for use when difficulties are encountered when requesting the attending physician to complete a Certificate of Medical Necessity.

If you have an ongoing problem receiving a completed CMN from the physician, you may contact your Ombudsman at 717-735-9666 and request that a letter be sent to the physician.

To: Treating Physicians

From: United HealthCare
Region A DMERC

Subject: Certificate of Medical Necessity Completion

The Region A DMERC processes all claims for durable medical equipment, orthotics, prosthetics, and supplies for Medicare beneficiaries in the 10 northeastern states. Certain items billed to the office cannot be processed without a completed Certificate of Medical Necessity. Section B3 3312 of the "Medicare Carriers Manual" (MCM) states, "For certain items or services billed to the DME Regional Carrier (DMERC), the supplier must receive a signed Certificate of Medical Necessity (CMN) from the treating physician."

It is your responsibility to provide the supplier with the necessary medical information for the item(s) that you order. Please review the attached Certificate of Medical Necessity and, upon completion, return it to the supplier as soon as possible. Please be sure to complete the following information in Section B, including the estimated length of need and the appropriate ICD-9 codes. Also, please be sure to answer all questions. Section D must contain your original signature and date of completion.

Medicare claims should only be submitted for processing to the Region A DMERC once all the necessary medical documentation for the claim has been received by the supplier (within a reasonable time frame). Failure to submit the required documentation can result in payment delays for either the supplier or the patient, depending on the assignment agreement.

Thank you in advance for your prompt attention to this important matter.

Oxygen CMNs

Supplier Notice 98-26
November 6, 1998

When submitting oxygen CMNs electronically, the arterial blood gas level or saturation level fields must be entered with a trailing zero (0). This is due to an implied decimal that the system enters between the 2nd and 3rd positions of the field:

Examples:

If ABG = 55, it must be entered on the CMN as 550, **NOT** 055

If SAT = 88, it must be entered on the CMN as 880, **NOT** 088

Please make sure this information is entered appropriately when submitting oxygen CMNs.

Crossover

Supplier Notice 98-27
November 6, 1998

As you may be aware, automatic claim crossover for some states was affected by the VIPS transition that occurred on July 1, 1998. The following Medicaid trading partners were affected: Massachusetts, Maine, New Hampshire, New Jersey, and Vermont.

This problem was corrected during the last week of October. At the request of the trading partners that were affected, we recreated and transmitted files that did not cross over between August 1, 1998 and October 8, 1998. For states other than New Jersey, we were unable to recreate affected July crossover volume. The alternative for any affected July volume is submission of EOMB copies to your Medicaid agency.

Clarification on Mandatory Claim Submission

Supplier Notice 98-28
November 6, 1998

The following information is provided to clarify mandatory claim submission requirements for assigned and nonassigned claims.

Section 1848(G)(4) of the Social Security Act requires physicians and suppliers to submit Part B assigned and non-assigned claims for processing by Medicare carriers. Physicians and suppliers are prohibited from imposing a charge for completing and submitting a claim to Medicare (MCM B3 3041).

The documentation section of each DMERC medical policy outlines what documents are necessary for claim submission. The assignment chosen does not effect the documentation requirements of a policy.

Correction to Erroneous Duplicate Denials

Supplier Notice 98-29
November 6, 1998

The Region A DMERC has encountered a problem that occurred during our recent system conversion. This problem has resulted in erroneous duplicate claim denials. It was discovered when suppliers received appropriate return/reject denials on or before June 30, and then resubmitted the claim on or after July 1.

This problem has been corrected. Claims processed on or after November 2, 1998, will not be affected.

We are currently adjusting the incorrectly denied claims. The target for completion of this adjustment task is December 31, 1998. This process has begun and some suppliers may already have seen adjustment transactions.

Clarification on Appropriateness of EOMB Messages

Supplier Notice 98-30
November 6, 1998

The Region A DMERC must use the appropriate denial codes outlined in Medicare Program instructions. We cannot substitute a specific denial with a non-coverage or other non-specific denial in an attempt to achieve reimbursement from a secondary payment source.

We are working closely with Medicaid agencies and other entities to clarify denial messages issued by Medicare for beneficiaries that have dual eligibility.

We do not issue non-coverage denials without receiving a complete, fully documented claim request.

EMC Throughput Prior vs. Post- transition

Supplier Notice 98-31
November 6, 1998

The term "throughput" defines claims that are billed electronically and process automatically to completion by the system, with no manual intervention.

Prior to the VIPS transition on July 1, 1998, the average rate of EMC throughput was 55%. Since the conversion, the throughput rate has increased to 73%, an increase of approximately 33%!

EMC claim analysis has detected that use of invalid HIC numbers is a key reason for claims stopping in the process instead of going to completion.

Increasing EMC throughput is beneficial for suppliers and the DMERC. We ask that you pay special attention to the HIC number issue. We'll provide information on other throughput "stoppers" in coming months.

Medicare Summary Notice

Supplier Notice 98-32
November 10, 1998

Effective October 29, 1998, the Explanation of Medicare Benefits (EOMB) for Part B was replaced by the Medicare Summary Notice (MSN). The purpose of the MSN is to provide a more understandable summary statement of claims processed for beneficiaries.

MSN's will be issued on a 30-day basis when the claims processed during that time do not generate any payment to the beneficiary. Claims processed that do not generate a payment to the beneficiary will result in issuance of an immediate MSN with the check. When payment to the beneficiary is for more than one claim and/or more than one supplier, all payments will be combined on one check. The MSN will provide a summary of the information.

In the future, we will have the capability to print Spanish MSN's when requested by the beneficiary. However, we are unable to print them at this time. You will be notified when this option is available.

For a sample of an MSN, refer to the September issue of "DME Provider News," #40.

Correction

Supplier Notice 98-33
November 12, 1998

Supplier Notice 98-32 contained an error. The second paragraph, second sentence, should read:

> **Claims processed that generate a payment to the beneficiary will result in issuance of an immediate MSN with the check.**

We apologize for any inconvenience this may have caused.

Addendum

Supplier Notice 98-34
November 12, 1998

Enclosed is an addendum to the attachment of Supplier Notice 98-25.

Please disregard the previous memo and begin use of the attached immediately.

To: Treating Physicians

From: United HealthCare - Region A DMERC

Subject: Certificate of Medical Necessity Completion

The Region A DMERC processes all claims for durable medical equipment, orthotics, prosthetics and supplies for Medicare beneficiaries in the 10 northeastern states. Certain items billed to the office cannot be processed without the necessary medical documentation. One very important piece of medical documentation is a Certificate of Medical Necessity. Section B3 3312 of the Medicare Carriers Manual (MCM) states, "For certain items or services billed to the DME Regional Carrier (DMERC), the supplier must receive a signed Certificate of Medical Necessity (CMN) from the treating physician."

Section B3 3041 of the MCM pertains to mandatory claim submission and states, "Section 1848 (g)(4) of the Social Security Act…prohibits physicians and suppliers from imposing a charge for completing and submitting a claim to Medicare." The Certificate of Medical Necessity is considered part of the actual claim; therefore, the physician cannot impose a charge for its completion.

* It is your responsibility to provide the supplier with all the necessary medical information for the item(s) that you order. Please review the attached Certificate of Medical Necessity, and upon completion, return it to the supplier as soon as possible. Please be sure to complete the following information in Section B: estimated length of need, the appropriate ICD-9 codes and all questions. Section D must contain your original signature and date of completion.

When all the necessary medical documentation for a Medicare claim is not received by the supplier in a reasonable time frame, the claim cannot be submitted to the DMERC for processing. This can cause payment delays of Medicare claims, either for the supplier or your patients, depending on the assignment agreement.

Thank you in advance for your prompt attention to this important matter.

Tips for Adjudicating Claims

Supplier Notice 98-35
November 16, 1998

The purpose of this notice is to address claim adjudication by explaining the correct steps to be taken given various initial denials.

(1.) Medical Review/Utilization Denials:

Claims reflecting any of the following denials on your Remittance Notice **cannot** be resubmitted. Resubmission of the claim may result in a CO-18 (DUPLICATE DENIAL). If you do not agree with a Medical Review Utilization denial, you must request a formal review for the denial to be reconsidered. **Please include the HICN, date of service, claim control number and a statement indicating why you disagree with the denial, along with any supporting documentation.**

PR PATIENT RESPONSIBILITY
46 THIS (THESE) SERVICES IS (ARE) NOT COVERED.

CO CONTRACTUAL OBLIGATIONS
46 THIS (THESE) SERVICES ARE NOT COVERED.

CO CONTRACTUAL OBLIGATIONS
B5 CLAIM / SERVICE DENIED / REDUCED BECAUSE COVERAGE GUIDELINES WERE NOT MET OR WERE EXCEEDED.

CO CONTRACTUAL OBLIGATIONS
50 THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A "MEDICAL NECESSITY" BY THE PAYER.

C0 CONTRACTUAL OBLIGATIONS
57 CLAIM / SERVICE DENIED / REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, OR THIS DOSAGE.

CO CONTRACTUAL OBLIGATIONS
107 CLAIM / SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM / SERVICE WAS NOT PAID OR IDENTIFIED ON THE CLAIM.

CO CONTRACTUAL OBLIGATIONS
114 PROCEDURE / PRODUCT NOT APPROVED BY THE FOOD AND DRUG ADMINISTRATION.

PR PATIENT RESPONSIBILITY
B7 THIS PROVIDER WAS NOT CERTIFIED FOR THIS PROCEDURE / SERVICE ON THIS DATE OF SERVICE.

(2.) Medicare Secondary Payer Denials:

Claims reflecting any of the following denials on your Remittance Notice **cannot** be resubmitted. Resubmission of the claim may result in a CO-18 (DUPLICATE DENIAL). If you do not agree with a Medicare Secondary Payer denial, you must forward you request for reconsideration to the attention of the Medicare Secondary Payer Unit. **Please include a copy of the Remittance Notice, the HICN, date of service, claim control number and a statement indicating why you disagree with the denial, along with any supporting documentation.**

PR PATIENT RESPONSIBILITY
19 CLAIM DENIED BECAUSE THIS IS A WORK RELATED INJURY AND THUS THE LIABILITY OF THE WORKER'S COMPENSATION CARRIER.

PR PATIENT RESPONSIBILITY
20 CLAIM DENIED BECAUSE THIS INJURY IS COVERED BY THE LIABILITY CARRIER

PR PATIENT RESPONSIBILITY
21 CLAIM DENIED BECAUSE THIS INJURY IS THE LIABILITY OF THE NO-FAULT CARRIER.

PR PATIENT RESPONSIBILITY
22 CLAIM DENIED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.

CO CONTRACTUAL OBLIGATIONS
23 CLAIM DENIED/REDUCED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER AS PART OF COORDINATION OF BENEFITS.

PR PATIENT RESPONSIBILITY
23 CLAIM DENIED/REDUCED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER AS PART OF COORDINATION OF BENEFITS.

PR PATIENT RESPONSIBILITY
38 SERVICE NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS.

(3.) Information or Invalid Information Denials:

Claims reflecting the following must be resubmitted.

CO CONTRACTUAL OBLIGATIONS
16 CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION

CO CONTRACTUAL OBLIGATIONS
B17 CLAIM/SERVICE DENIED BECAUSE THIS SERVICE WAS NOT PRESCRIBED BY A PHYSICIAN, NOT PRESCRIBED PRIOR TO DELIVERY, THE PRESCRIPTION IS INCOMPLETE, OR THE PRESCRIPTION IS NOT VALID.

(4.) Adjustment Requests:

An adjustment can be requested when an error was made by the DMERC that caused the denial. Please forward adjustment requests to:

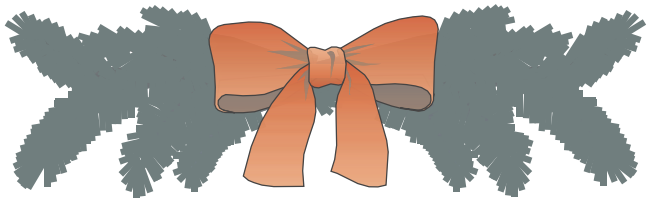
United HealthCare Insurance Company – Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: **Adjustment**

There is no need to call the Provider Services Unit prior to submitting an adjustment request. If the error was, in fact, made by the DMERC, we will make the correction. If the claim was processed correctly, you will be notified. If a Medical Review/Utilization Denial is not overturned, you will receive an affirmation letter from the Review Department, indicating what your appeal rights are. Refer to Supplier Notice 98-24.

(5.) Incorrect CO-18 Denials:

The DMERC is in the process of adjusting all incorrect CO-18 denials. Our goal is to complete this by December 31, 1998. Incorrect CO-18 denials occurred on claims that denied prior to July 1, 1998 and then were denied incorrectly as duplicate when they were resubmitted after July 1, 1998.

Claims that denied before and after July 1, 1998 with a Medical Review/Utilization denial or an MSP denial that had been resubmitted after July 1, 1998 was also denied CO-18. The claims will not be adjusted because they should not have been resubmitted. Please follow the correct adjudication procedure referred above for the initial MR/UR or MSP denial. Please make reference of this information and follow the appropriate procedures.



Season's Greetings

DMERC Medicare News

United HealthCare Insurance Company • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800