

DME Claims Filing Changes & Common Claim Errors



PRESENTED BY:
Pamela B Fritz
pmdresources@sbcglobal.net
(860) 669-9057

Pamela Fritz, an optical industry veteran of over 30 years, is President of Ophthalmology Resources, Inc, a firm which specializes in financial and operational management of the optical dispensary.

Their clients include 100's of dispensing MD and OD practices across the US. They specialize in start-up dispensaries for MD's. Fritz is an expert in Medicare Post-op Cataract Eyewear giving workshops nationwide and at the AAO Annual Meeting.

She is a consultant to the AAO's Medicare Coding and Billing Division and will author the new edition of the AAO's Medicare Optical Module.

She serves on the Provider Outreach and Education Panels for Medicare's DME Contractors in Region A (NHIC) Region B (NGS) and Region D (Noridian).

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Timeline for Filing

- **Change effective March 23, 2010**
- **Reduced time period to 1 calendar year after the date of service.**
- **After Jan 1, 2010 – claims filed within 1 year**
- **Dec 31, 2010 was deadline for prior claims**

CEDI Transition to NSV May 1, 2011

- **www.NGSCEDI.com**
- **Does your software utilize a Gateway NSV?**
- **PC-ACE Pro32 Software Users must have an NSV**
- **NSV – more secure and greater connectivity**
- **On-line claim status inquiry (ERA)**

Network Service Vendors

- Claim Shuttle www.claimshuttle.com
- Cortex,EDI, Inc. www.CortexEDI.com
- ECC Technologies www.ecctec.com
- McKesson Care Bridge www.carebridge.net
- MedXpress www.medxpressclaims.com
- Nebo Systems, Inc. www.nebo.com
- Ability (Vision Share) www.abilitynetwork.com
- IVANS www.ivans.com

Section 3

3. PATIENT'S BIRTH DATE			SEX	
MM	DD	YY	X	F
01	23	1944	<input type="checkbox"/>	<input type="checkbox"/>

- Patients 8 digit birth date

Section 4

4. INSURER'S NAME (Last Name, First Name, Middle Initial)
Same

- 4 – "SAME"

Section 5

5. PATIENT'S ADDRESS (No. Street)	
123 Main St	
CITY	STATE
Anywhere	US
ZIP CODE	TELEPHONE (Include Area Code)
12345	(123)456 7890

- 5 – Complete Address – Do not use punctuation

Section 9 a - d

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
2. OTHER INSURED'S POLICY OR GROUP NUMBER Medigap 123456	
6. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME AARP, street, city & zip	

- > 9 -
- > 9 a - "Medigap" and Beneficiary Secondary Policy #
- > 9 b -
- > 9 c -
- > 9 d - Name of Insurance Co., Address

Section 10 a - d

10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. AUTO ACCIDENT? PLACE (State)	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. OTHER ACCIDENT?	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10c. RESERVED FOR LOCAL USE MCD	

- > 10 a - c - Print 'X' in "NO" boxes
- > 10 d - Medicaid

Section 11 a - c Secondary Insurance Information

11. INSURED'S POLICY GROUP OR ILECA NUMBER None	
2. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	

- > 11 - "None"
- > 11a - Leave Blank
- > 11b - Leave Blank
- > 11c - Leave Blank

Section 12 - 13

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than Medicaid to be paid to the party who manages my payment. SIGNED: John Q Public DATE: 04-10-11	
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: John Q Public	

- > Paper Claims: Date is day the order was placed

Section 14 – 17 b

14. DATE OF CURRENT ILLNESS (Not Applicable) OR BLEEDY (Amovio) OR PREGNANCY (AMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE Seymore MD	17a. NPI 17b. NPI 1234567890

- 14 – Leave Blank
- 15 – Leave Blank
- 17 – Name of the ophthalmologist or optometrist who provided the Rx
- 17 a – Leave Blank
- 17 b – NPI of the ophthalmologist or optometrist listed in 17

Section 16, 18, 20, 22-23

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY
18. HOSPITALIZATION DATES RELATED TO CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY
20. OUTSIDE LAB? \$ CHARGE \$ <input type="checkbox"/> YES <input type="checkbox"/> NO
22. MULTICARD REQUISITION CODE ORIGINAL RJ. NO.
23. PRIOR AUTHORIZATION NUMBER

- 16, 18, 20 - Leave Blank
- 22 - 23 – Leave Blank

Section 19, 21

19. REFERRED FOR LOCAL USE Cataract Surgery: R 03-11-2011
21. DIAGNOSIS ON NATURE OF ILLNESS OR INJURY. (Pick one 1, 2, 3 or 4 to item 21E by Line)
1. V43.1
2.

- 19 - Enter surgery dates) using “R” or “L”. CMS does not recognize ‘OD’ and ‘OS’ as right and left designations
- 21.1. - Enter a diagnosis code from the following:
 - V43.1 – Pseudophakia 379.31 - Aphakia (no implant)
 - 743.35 – Congenital Aphakia
- 21.2. –
- 21.3. –
- 21.4. –

Section 24 A - C

Y	24. A. DATES OF SERVICE						B. PLACE OF SERVICE	C. ICD
	From	To	From	To	From	To		
	MM	DD	YY	MM	DD	YY		
1	04	15	11	04	15	11	12	
2	04	15	11	04	15	11	12	
3	04	15	11	04	15	11	12	
4	04	15	11	04	15	11	12	

- 24 A - Date of Dispensing in both “From” and “To” fields
- 24 B - Place of Service is always “12”, which refers to items that the patient uses in their home
- 24 C - Leave Blank

Section 24 D - E

D. PROCEDURE, SERVICE, OR SUPPLY (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER
CPT/HCPCS	MODIFIER	
V2020		1
V2305	RT,LT	1

- Medicare covered items on separate claim
- RT for right eye LT for left eye

Section 24 D - E

D. PROCEDURE, SERVICE, OR SUPPLY (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER
CPT/HCPCS	MODIFIER	
V2025	EY,GA	1
V2781	RT,LT,EY,GA	1
V2750	RT,LT,EY,GA	1

- Non- Covered Items on Separate Claim Form - EY Modifier

Section 24 D - H

D. PROCEDURE, SERVICE, OR SUPPLY (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DATE PER UNITS	H. UNITS PER DAY
CPT/HCPCS	MODIFIER				
V2020		1	00.00	1	
V2305	RT,LT	1	00.00	2	

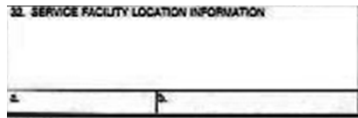
- 24 F - Enter Medicare covered allowance
- 24 G - Units
- 24 H - Leave Blank

Section 24 D - H

D. PROCEDURE, SERVICE, OR SUPPLY (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DATE PER UNITS	H. UNITS PER DAY
CPT/HCPCS	MODIFIER				
V2025		1	00.00	1	
V2781	RT,LT,EY,GA	1	00.00	2	
V2750	RT,LT,EY,GA	1	00.00	2	

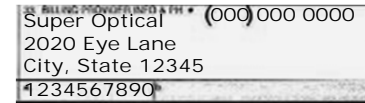
- 24 F - Enter Non covered amounts
- 24 G - Units
- 24 H - Leave Blank

Section 32 a - b

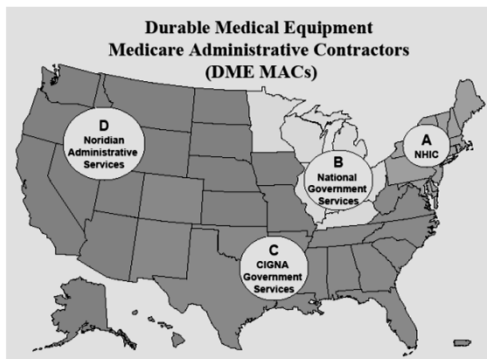


➤ If place of service is 12 it is not necessary to fill this out

Section 33



- 33 – Provider/Supplier billing name, address, zip code, telephone,
- 33 a – Supplier NPI
- 33 b - Leave Blank



DME MAC
(Medicare Administrative Contractor)
web-sites

- Region A www.medicarenhic.com
- Region B www.ngsmedicare.com
- Region C www.cignagovernmentservices.com
- Region D www.noridianmedicare.com

www.cms.gov

Latest News For DME Suppliers

- Re-enrollment is now Re-validation
- New \$505 enrollment fee
- Must supply “hardship” letter with enrollment forms
- No claim reject deadline for PECOS yet

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Thank You!

For attending today's Webinar

Pam Fritz is available for further individual consultation to solve all your DME issues.

**Consultation Fees
Available Upon Request**

To set up an appointment

Call 860-669-9057

Or Email

pfdresources@sbcglobal.net

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