Durable Medical Equipment for Medicare Advantage Plans Frequently Asked Questions

Key Points

- UnitedHealthcare uses the Centers for Medicare & Medicaid Services (CMS) coverage criteria to help develop our policies and payments for durable medical equipment (DME) for Medicare Advantage members.
- DME vendors must be contracted with UnitedHealthcare to participate in UnitedHealthcare's Medicare Advantage network.
- We ask that you follow our coverage guidelines and provide supporting documentation when requesting DME services for UnitedHealthcare Medicare Advantage members.
- Please use our online self-service tools at UHCprovider.com to verify member eligibility and coverage options.

Overview

This document includes commonly asked questions about member eligibility for DME services, how to submit requests for notification/prior authorization for DME services when needed, and information about claims reimbursement.

Frequently Asked Questions and Answers

Eligibility for DME Services

Q1. Does UnitedHealthcare require participating DME care providers and vendors to follow CMS criteria for DME?

A1. Yes. UnitedHealthcare follows CMS coverage criteria for reimbursing DME vendors that participate in our Medicare Advantage network.

Q2. How can I check a UnitedHealthcare member's eligibility for DME services?

A2. **Online:** Use eligibilityLink to check member eligibility and review detailed benefits information. To access eligibilityLink, sign in to Link by clicking on the Link button in the top right corner of UHCprovider.com. Then select the eligibilityLink tool on your Link dashboard.

Phone: You can also verify a member's eligibility by calling the Provider Services number on the member's ID card.

Your Link dashboard also has referralLink and Prior Authorization and Notification tools to check referrals and notification/prior authorization for UnitedHealthcare members.

Notification/Prior Authorization

Q3. Is notification/prior authorization required for DME services?

A3. Select DME services require that you submit a notification/prior authorization request. A list of Healthcare Common Procedure Coding System (HCPCS) codes that require notifications or prior authorizations is included in the United Healthcare Administrative Guide at UHCprovider.com > Menu > Administrative Guides and Manuals. We also periodically include updates to the Administrative Guide in the monthly *Network Bulletin* at UHCprovider.com > Menu > News and Network Bulletin.

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Q4. How do I submit a request for a notification/prior authorization?

A4. Here's how you can submit a notification/prior authorization request:

- **Online:** Use the Prior Authorization and Notification tool on Link. To sign in to Link, go to UHCprovider.com and click on the Link button in the top right corner. Learn more about using the Prior Authorization and Notification tool at UHCprovider.com > Prior Authorization and Notification.
- **Phone:** Call **877-842-3210** (option 3) or call the number on the member's health plan ID card.

Regardless of the method you use to request notification/prior authorization, please provide the appropriate HCPCS codes and associated units.

Q5. How do I determine rental vs. purchase for DME services?

A5. You can find the rental vs. purchase guidelines in the payment appendix attached to your Participation Agreement. Additional information about reimbursement policies and guidelines for DME service is available at UHCprovider.com > Menu > Policies and Protocols.

Q6. Why does my authorization show a different HCPCS code than I requested?

A6. If the authorization letter shows a different HCPCS code than you requested, please review the authorization letter and compare it to your submitted request. If you have questions, please refer to the contact number on the authorization letter or call the Provider Services number on the member's health plan ID card.

Claims Reimbursement

Q7. How does UnitedHealthcare reimburse DME services?

A7. We reimburse DME services according to your Participation Agreement, fee schedule, policies and protocols.

Q8. How do I determine what HCPCS code to use when I submit a claim?

A8. Please use the Medicare Pricing, Data Analysis and Coding (PDAC) for coding at dmepdac.com.

Q9. What information should I include on the claim?

A9. Please include:

- The appropriate HCPCS code
- The appropriate number of units/modifier
- The approved authorization number, if applicable

Q10. If I disagree with a claim adjudication, what can I do?

A10. You can submit a claim reconsideration request and we'll review the claim decision. The reconsideration must be within12 months from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA), or as required by law or your Participation Agreement. Submit a reconsideration request in the following ways:

- **Online**: Use claimsLink to submit a corrected claim or claim reconsideration or track claim reconsideration requests. Learn more about using claimsLink at UHCprovider.com/claims.

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    - If a request involves 20 or more paid or denied claims and attachments aren't required, combine and submit these claims online.
    - More information is at UHCprovider.com/claims > Submit Reconsideration Requests for Multiple Claims.
- **Mail**: The form, instructions and the mailing address information to submit are available at UHCprovider.com/claims > Submit a Corrected Claim, Claim Reconsideration/Begin Appeal Process.
- **Call**: Call the number on the back of the member's health plan ID card to request an adjustment for a claim that doesn't require written documentation.

Q11. Who do I contact if I have questions?

A11. Please contact your Provider Advocate with questions.

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