DME Medicare News

DMERC Region A Service Office ❖ P. O. Box 6800 ❖ Wilkes-Barre, PA 18773-6800

No. 12 The Travelers September, 1994

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Contacts

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Bulletin Board
Participating Suppliers . . . . . (800) 842-5713
Non-Participating Suppliers . . . . . (717) 735-9515
EMC FAX. . . . . (717) 735-9510
National Supplier Clearinghouse. . . . . (803) 754-3951
Supplier Number
Until October 1, 1994. . . . . (800) 842-2563
After October 1, 1994. . . . . (717) 735-9445

The Region A "DME Medicare News" is published by The Travelers Government Operations DMERC Professional Relations Unit for DMEPOS suppliers in Region A. For further information on this publication, please contact:

The Travelers
Region A DMERC
Professional Relations - Outreach
P. O. Box 6800
Wilkes-Barre, PA 18773-6800

Joanne Quaglia, Editor (717) 735-9405

Beneficiary Information

The Region A DMERC has been receiving requests from suppliers, beneficiary organizations, and other individuals seeking beneficiary information. The Freedom of Information Act prohibits the DMERC, along with other carriers, from disclosing beneficiary information to individuals or organizations other than the beneficiary without the beneficiary's written consent.

In order for the Region A DMERC to disclose beneficiary information, written consent, authorized by the beneficiary or the beneficiary's legal guardian, must be submitted to the DMERC. The authorization may be in any form and it must:

- ❑ Be signed and dated by the beneficiary or the beneficiary's legal guardian.
- ❑ Specify the individual, organizational unit, class of individuals, or organizational units to which the information may be disclosed;
- ❑ Specify the record(s), information or type(s) of information which may be disclosed; and
- ❑ Indicate whether the consent is a one-time or ongoing release.

Authorized consent for the release of beneficiary information, including the above specifications, must be sent to:

The Travelers Insurance Group
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: Beneficiary Services

Workshop Location Change

The location for the Post-Transition Workshop in Boston on October 10, 1994, has been changed. See page 11 for details.

Medical Policy

Documentation for Oxygen Flow Greater Than 4 L/M

When oxygen is ordered at flow rates greater than 4 L / M (liters / minute) there should be documentation of the need for the higher flow rate. Acceptable documentation would consist of arterial blood gases or oxygen saturation levels performed while the patient is breathing at least 4 L / M, demonstrating a degree of hypoxemia which would require a flow rate even higher than 4 L / M. This documentation should be submitted with the initial certification.

Hip Chairs - Non-Covered

The DMERC has been receiving claims for hip chairs (chairs with higher than normal seats). The SADMERC has determined that these should be billed using HCPCS code E1399. The claim should contain a complete description of the item. It will be denied as non-covered by Medicare. (It could be useful to a person in the absence of illness or injury.)

Home Dobutamine Infusion

The Region A DMERC Medical Policy on Infusion Pumps lists criteria for coverage of home dobutamine infusion. (Refer to the Region A Supplier Manual, Revision 003, March, 1994, Chapter 13, page 13-108.) Region A DMERC will begin considering coverage of dobutamine infusion and other parenteral inotropic drugs for patients who are not cardiac transplant candidates on an individual consideration basis. Information on the expanded criteria and a suggested form for data collection and submission to the DMERC may be requested from our DMERC Provider Relations Department at P. O. Box 6800, Wilkes-Barre, Pa. 18773-6800. Include your name, address and supplier number on the request. You may also contact the Ombudsman who services your state for this information.

Cladribine (Leustatin)

This drug is used in the treatment of Hairy Cell Leukemia. It requires a constant infusion over a course of seven days. This drug will be covered when administered via a covered external infusion pump for a diagnosis of active hairy cell leukemia (ICD-9-dx Code 202.4) as defined by clinically significant anemia, neutropenia, thrombocytopenia or disease related symptoms. Use HCPCS code J7799 with a complete description of the drug, dosage and frequency of administration.

Prograf (Tacrolimus; FK-506)

This immunosuppressive drug has received FDA approval for use with liver transplants. Prograf will therefore be added to the list of immunosuppressive drugs covered by the DMERC when used to prevent rejection of liver transplants.

Because there is much current research and literature indicating its usefulness in renal, and other organ transplants, if the physician supervising the post-transplant care of the patient decides, in his / her best clinical judgment, that Prograf should be used as part of the primary immunosuppressive drug regimen for other Medicare approved organ transplants (as well as the liver), the Region A Medicare DMERC will cover the Prograf.

Surgical Dressings Used With Gastro-Jejunostomies

If it is necessary to use dressings to protect the skin from secretions sometimes associated with gastro-jejunostomies, only gauze pads (non-impregnated, with or without adhesive borders, K0216 or K0219), in reasonable quantities, will be reimbursed. If higher category surgical dressings are billed for this use, extra documentation describing the medical necessity is needed for consideration of claim reimbursement.

Chiropractic Physicians Prescribing of DMEPOS

Medicare regulations do not allow for coverage of a service when a chiropractic physician is the prescribing physician. This includes laboratory examinations, x-rays, and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS).

Transtracheal Catheters Used in Delivery of Home Oxygen Therapy

The use of home oxygen equipment is covered under the durable medical equipment (DME) benefit of the Medicare program. Catheters used in the administration of transtracheal oxygen are also covered as DME supplies in those cases in which they are medically necessary for the patient to receive home oxygen treatment.

Medicare's payment rules for home use of oxygen are governed by sections 1834 (a) (5) and (9) of the Social Security Act. These sections require that Medicare pay for home use of stationary oxygen with a single monthly payment amount that includes the oxygen equipment and all necessary supplies. The law does not permit separate payment for any additional items (such as masks, tubing, humidity jars, or transtracheal catheters) used in furnishing oxygen to a patient. The monthly payment amount already includes an allowance for such devices. Therefore, for Medicare to pay a separate amount for such devices would result in duplicate payments since the price of these items has already been included in the base for the fee schedule payment amount for home oxygen therapy.

Because the fee schedule amount for home oxygen includes an allowance for all necessary supplies, suppliers are obligated, without additional payment, to provide transtracheal catheters (including replacements as often as medically necessary) to Medicare recipients when ordered by a physician for purposes of home oxygen. When the attending physician specifies delivery through a transtracheal catheter in item 5 of the HCFA 484 (as indicated in the MCM at 312.A.10), the oxygen equipment provided by the supplier must conform fully to what has been prescribed in order to be covered.

Medicare participating physicians and suppliers have agreed to accept the Medicare approved amount as total payment for covered services for oxygen therapy in the home. The same is true for nonparticipating doctors or suppliers who agree to take assignment in a particular case. These doctors and suppliers are prohibited from charging Medicare recipients a separate amount for the catheter in the administration of oxygen. They are allowed to charge only for the annual deductible that the recipient has not met, and for the coinsurance, which is the remaining 20% of the approved amount.

ZY Modifier - For Potentially Non-Covered Services

A supplier usually does not bill the Medicare program for noncovered services. However, if the beneficiary (or his / her representative) believes that a service may be covered or desires a formal Medicare determination, the supplier must file a claim for that service to achieve the beneficiary's right to a determination. The supplier should note on the claim his / her belief that the service is noncovered and that it is being submitted at the beneficiary's insistence. The ZY modifier - "Potentially noncovered item or service billed for denial or at the beneficiary's request (not to be used for medical necessity denials)" - may be used in place of a statement on a claim or EMC narrative to satisfy the documentation requirement described above. This modifier is informational only. Coverage decisions are made based on the item billed and other pertinent information on the claim without regard to the presence or absence of this modifier. Its intent is to facilitate billers in meeting the documentation requirement.

Improper Coding of Indwelling vs. Intermittent Urinary Catheters

When billing the DMERC for intermittent catheterization, the proper codes to use are A4351 or A4352. Because indwelling Foley catheters are not used for this purpose, the following codes should not be used: A4338, A4340, A4344, A4346 (various Foley type catheters); A4311 - A4316 (insertion trays, with / without drainage bags, with various types of indwelling Foley catheters).

ICD-9 CM Codes

Either an ICD-9 CM code or a written narrative diagnosis is acceptable for Question 15 (DMERC CMN 10.01) as sufficient documentation to justify the medical necessity for the use of the Enteral and Parenteral Infusion Pumps (B9000 - B9006) and all nutrients, including specialty products.

B9000 - Enteral Infusion Pump, without alarm
B9002 - Enteral Infusion Pump, with alarm
B9004 - Parenteral Infusion Pump, portable
B9006 - Parenteral Infusion Pump, stationary

1. When an ICD-9 CM code is used, the code should provide the same information that a written narrative would contain.

2. If Question 15 is left blank, the ICD-9 CM codes on the claim form (block 21) or located in the diagnosis section of CMN 10.01 will not be used for pump justification, and the claim will be denied for lack of documentation.

If you have any questions regarding this notice, please direct them to your Ombudsman.

Extension of Parenteral Nutrition Grandfathering

For parenteral nutrition, if it has been approved by the prior regional carrier, payment will be continued by the DMERC. Payment under the grandfathering provision, scheduled to expire with dates of service on and after September 1, 1994, has been extended. PEN suppliers will be given a 45 day notice prior to the elimination of the grandfathering provision for parenteral nutrition.

Electronic Media Claims

Interested in a cost-effective and accurate method of submitting DMEPOS claims? Electronic billing can supply the solution. The Travelers offers a *free* software program called "Accelerate." Accelerate uses a claim entry that resembles the HCFA-1500 form.

Electronic submission of claims is available to both participating and non-participating suppliers. Assigned and non-assigned claims are accepted. The EMC Team is available to assist with software installation and to provide the support needed to run this program. By following the steps below, the EMC Team can start today to help suppliers with electronic billing, even those using a vendor or billing service.

To Use the Accelerate Software

1. Contact the EMC Team by phone, mail, or FAX.
2. The EMC Unit will issue a submitter number and send the Accelerate software free of charge.
3. EMC representatives will help you install and transmit DMEPOS claims after the EMC signature agreement is returned.

To Use a Vendor/Billing Service

If you are using a vendor or billing service:

1. Contact the EMC team by phone, mail, or FAX.
2. The EMC Unit will issue a submitter number and send testing information. Contact your vendor/billing service to arrange for testing of a minimum of 10 to 20 claims. Once testing is passed and the EMC signature agreement is returned to the DMERC, transmission of DMEPOS claims will begin.
3. Our EMC Team will be glad to assist you with setting up the transmission of claims through a vendor/billing service. The EMC Department can supply a vendor and billing service list upon request.

For additional information or to receive the free Accelerate software, complete the form and return it to the EMC Department.

✂ *Cut Here*

Request for EMC Information

Office Name: _____

Address: _____

City/State: _____

Phone Number: _____ Zip Code: _____

Contact Person_____:

NSC #: _____ DMEPOS Volume (Claims/Month):_____

_____ I am interested in receiving the free Accelerate software. (Please check the size of your disk drive A: _____ 3 1/2" *or* _____ 5 1/4")

_____ I would like more information regarding EMC submission.

_____ My computer system is supported by _____ (Indicate name of vendor/billing service).

Please have an EMC Representative call me.

Please complete this form and mail or FAX to:

FAX To: The Travelers Region A DMERC
(717) 735-9510
ATTN: EMC Unit

Mail To: The Travelers Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18663-6800
ATTN: EMC Unit

Contacting the EMC Team

The EMC Help Desk toll-free number (800-842-1305) is no longer in service. If you need assistance, the EMC Team may be contacted at:

- ❑ (717) 735-9517
- ❑ (717) 735-9518
- ❑ (717) 735-9519
- ❑ (717) 735-9527

The Bulletin Board System

The Bulletin Board System is not only used for submitters to submit claims, but also for the EMC Unit to leave messages for submitters regarding any updates, changes, or revisions on electronic issues, medical policies, or newsletter updates. These messages are a vital tool for keeping suppliers updated on all issues. Please read these messages when dialing into the Bulletin Board System.

Electronic Acknowledgment File

The electronic acknowledgment file is available through the Region A DMERC's electronic Bulletin Board's menu option J, "Acknowledgement Reports." To access the electronic Bulletin Board, call:

(800) 842-5713 For Participating suppliers

(717) 735-9515 For non-participating suppliers

Electronic claim files received before 1:00 p.m. each day will be processed that night. The electronic acknowledgment will be available on the Bulletin Board by 8:00 a.m. on the following day.

Electronic claim files received after 1:00 p.m. (Monday), will be processed Tuesday night. The electronic acknowledgment will be available on the Bulletin Board by 8:00 a.m. on Wednesday.

Electronic acknowledgments will remain on the Bulletin Board for 10 working days. However, space on the Bulletin Board is limited. Please retrieve the files promptly. New files will not overlay uncollected acknowledgments from prior days. Paper acknowledgments will continue to be available until further notice.

Weekly Status Reports and ERNs

Effective August 8, 1994, the Weekly Status Report and the Electronic Remittance Notices for EMC Submitters will remain on the Bulletin Board System for 10 working days. Please contact the EMC Unit if you have any questions.

Additional Documentation

In addition to the actual transmittals, the following documentation files are also available under the Bulletin Board's menu option G, "System Support Files":

- ❑ Electronic Claim Acknowledgment
- ❑ File Format Explanation (in Word for Windows)
- ❑ Error Code Explanation (in Word for Windows)
- ❑ File Format Explanation (in ASCII)
- ❑ Error Code Explanation (in ASCII)

The File Format Explanation Document is approximately seven pages. The Error Code Explanation Document is approximately 45 pages.

EMC Billing Reminders

1. Make sure to use zeros in the submitter number and not the alpha character O. The system will reject the claim if it is not correct (e.g., A08000001).

2. The beneficiary's Health Insurance Claim (HIC) number must be properly constructed. Use the correct amount of numeric characters and alpha characters for each number. There should not be any spaces in the HIC number.

3. The physician's full name and UPIN number must be included on all claims. The first name must be at least two letters; e.g., FB1 6, FB1 7, FB1 9. The physician's phone number is also required. This must have a valid area code or the system will reject the claim (GU0 23).

4. If secondary insurance information is included on the claim and it is a Medigap policy, the OCNA number (Other Carrier Name and Address) must be entered (DA0 7). If the insurance is a supplemental policy, an OCNA number is not required.

5. The Source of Payment Indicator must be included on all claims with primary or secondary insurance (DA0 5).

6. If a Certificate of Medical Necessity is sent in with the claim and it is the first CMN for the patient, the initial date must be filled in with a valid date (GU0 19).

7. If there is a change to the current CMN or a recertification is due, these dates must be included on the CMN (GU0 20). If it is not a revised or recertification, this field can be blank.

8. The date of last medical examination is required on the CMN (GU0 18).

9. Your entire NSC number must be included on every claim (e.g., 9801540025). The biller code must be the first 6 digits of the NSC number (e.g., 980154).

10. Always refer to the HCPCS procedure code when billing number of services (e.g., lancets 1 box of 50 = 1 number of services).

EMC Percentage

The percentage of EMC claims received for the month of July was 64%. All claims can be submitted electronically, whether they are assigned or non-assigned claims. Claims with additional documentation can also be sent electronically, using the extra narrative field (HA0 5). If you have any questions about submitting claims electronically, please call the EMC Unit.

Vendors

Suppliers using a vendor's software to submit claims electronically are required to test the format with one DMERC. Additionally, if they are submitting to other regions, the suppliers must also test communications with those DMERCs. If suppliers are using an approved vendor, they may either use the test packages or submit 10 to 20 claims for testing. If suppliers are billing for items with Certificates of Medical Necessity (CMN), at least half of the test claims must have CMNs. Once a test is submitted, results will be given within one to three working days. When the test is passed and the Region A DMERC has received the EMC Agreement, the supplier will be allowed to submit electronically.

Suppliers who have not yet tested must contact the EMC Unit at:

- ❑ (717) 735-9517
- ❑ (717) 735-9518
- ❑ (717) 735-9519
- ❑ (717) 735-9527

Region A DMERC Opens New Office

The Travelers Region A DMERC is now located at 60 East Main Street, Nanticoke, PA 18634-1685. However, the mailing address for the Region A DMERC remains the same. Claims and correspondence must be sent to:

Region A DMERC
The Travelers Insurance Group
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

The telephone numbers of the DMERC staff have changed. The new numbers for key DMERC staff and service units are listed on the following pages. Two directories are available: an alphabetical directory and a functional directory.

For your convenience and ease of use, the directories are printed on perforated paper so that they may be detached from this newsletter.

Region A DMERC
Alphabetical Directory

Mailing Address:

Region A DMERC
The Travelers Insurance Group
P. O. Box 6800
Wilkes-Barre, PA 18773-6800

Connie Parry
District Manager
(717) 735-9501

Telephone: (717) 735-9400
FAX: (717) 735-9402

Office Location:

Region A DMERC
The Travelers Insurance Group
60 East Main Street
Nanticoke, PA 18634-1685

Steve Crittenden
Manager
(717) 735-9502

B

Vikki Bacso
Professional Relations Manager . . . . (717) 735-9410

Diane Belles
Professional Relations
Nurse Consultant . . . . . (717) 735-9411

Mary Boggs
Provider Services Manager . . . . . (717) 735-9450

C

Beth Chabala
Electronic Media Claims Manager . . (717) 735-9516

D

William Davis
Accounting,
Medicare Secondary Payor,
Manager. . . . . (717) 735-9555

F

Karen Furman
Pricing Manager . . . . . (717) 735-9420

M

Sherry Melonas
Medical Review Manager . . . . . (717) 735-9540

N

Joanne Nerbecki
Program Integrity Manager. . . . . (717) 735-9430

R

Geraldine Ram
Beneficiary Services Manager . . . . . (717) 735-9470

S

Cheryl Snow
Mail and Control Manager . . . . . (717) 735-9590

Terrence Southward
Claim Entry Manager (Day) . . . . . (717) 735-9600

Doris Spencer
Ombudsman: New England. . . . . (717) 735-9412

Martin Szmal
Ombudsman: PA, DE, NJ . . . . . (717) 735-9414

T

Vince Temples
Ombudsman: NY . . . . . (717) 735-9413

Dwayne Thomas
Claim Entry Manager (Nights) . . . . . (717) 735-9495

V

John Van Sicklin
Claim Entry Manager . . . . . (717) 735-9666

Region A DMERC
Functional Directory

General

General Information
If Not Listed Below . . . . . (717) 735-9400
FAX . . . . . (717) 735-9402

Managers

District Manager
Connie Parry . . . . . (717) 735-9501

Manager
Steve Crittenden . . . . . (717) 735-9502

Accounting

Manager
William Davis . . . . . (717) 735-9555

Beneficiary Services

Manager
Geraldine Ram . . . . . (717) 735-9470

General Information
Local . . . . . (717) 735-7383
Toll-Free . . . . . (800) 842-2052

Claim Entry

Manager
John Van Sicklin . . . . . (717) 735-9666

Manager, Day
Terrence Southward . . . . . (717) 735-9600

Manager, Night
Dwayne Thomas . . . . . (717) 735-9495

Electronic Media Claims

Manager
Beth Chabala . . . . . (717) 735-9516

Bulletin Board
Participating Suppliers . . . . . (800) 842-5713
Non-Participating Suppliers . . . . . (717) 735-9515

FAX . . . . . (717) 735-9510

Mail & Control

Manager
Cheryl Snow . . . . . (717) 735-9590

Medical Review

Manager
Sherry Melonas . . . . . (717) 735-9540

Medicare Secondary Payor

Manager
William Davis . . . . . (717) 735-9555

National Supplier Clearinghouse

NSC . . . . . (803) 754-3951

Pricing

Manager
Karen Furman . . . . . (717) 735-9420

Professional Relations

Manager
Vikki Bacso . . . . . (717) 735-9410

Nurse Consultant
Diane Belles . . . . . (717) 735-9411

Ombudsmen
Doris Spencer (New England) . . . . . (717) 735-9412
Martin Szmal (Delaware, New Jersey, Pennsylvania) . . (717) 735-9414
Vince Temples (New York) . . . . . (717) 735-9413

Program Integrity

Manager
Joanne Nerbecki . . . . . (717) 735-9430

Provider Services

Manager
Mary Boggs . . . . . (717) 735-9450

Supplier Number
Until October 1, 1994 . . . . . (800) 842-2563
After October 1, 1994 . . . . . (717) 735-9445

Fraud and Abuse

Scam Targets Seniors

The following article is being published to alert beneficiaries to a fraudulent use of the Medicare program. Medicare recipients should always take precautions. It is recommended that beneficiaries never share personal Medicare information, such as Explanation of Medicare Benefits (EOMB) statements or Medicare cards. Beneficiaries should always remember that Medicare representatives never solicit door to door.

Even though this most recent practice of Medicare fraud is believed to be confined to the Florida area, the Region A DMERC finds it important to notify beneficiaries to take precautions to prevent them from being victims of fraudulent Medicare practices.

MEDICARE SCAM TARGETS SENIORS — *Michele Chandler, Miami Herald, June 2, 1994*

They appear at senior citizen's doorsteps claiming they need to review the senior's monthly Medicare benefit statements to ensure they're correct.

But fraud, not accuracy, is the aim here. Benefit statements contain seniors' Medicare numbers, which are passed on to crooked medical providers who bill Medicare for non-existent medical treatments.

Insurance officials say these door-to-door visitors are just part of the latest scam to cheat Medicare, the federally funded health program for the elderly.

Officials for Blue Cross, which is the state administrator for Medicare and representatives for the U.S. Attorney's office who track health-care fraud became aware of the scam last month, said Debra Fulton, Outreach Educator with Blue Cross' Medicare Fraud Branch.

Blue Cross can't say how many people have been approached by scam artists or how much money this scam siphoned off from Medicare and the other insurance companies that pay a portion of health care costs for seniors receiving Medicare.

Investigations are on-going, but no arrests have been made so far. The scam is believed to be confined to Dade and Broward counties.

Medicare recipients should be on alert if someone claiming to represent Medicare comes to their home asking questions.

Medicare representatives never go door to door, said Blue Cross spokesman Marty Fillpowski. Usually written information will go out monthly with the Explanation of Medicare Benefits.

Medicare Secondary Payor

Claims submitted for reimbursement under the Medicare Secondary Payor benefit will require completing Blocks 28, 29 and 30 in the following manner:

Block 28 Fill in with the total of the actual charges submitted to the primary insurance company entered in Block 24F.

Block 29 Fill in with the total amount paid by the beneficiary (do not include any amount paid by the primary insurance company).

Block 30 Fill in the difference between blocks 28 and 29.

Do not provide any information in Blocks 28,29 and 30 regarding payment(s) made by the primary insurance company.

When submitting to the DMERC, include:

- ❑ The Explanation of Benefits (from the primary insurance company),
- ❑ A completed HCFA-1500 form, and
- ❑ If the item or service, according to the RMRP, requires a Certificate of Medical Necessity (CMN), a completed CMN.

Electronic claim submitters must include, in the extra narrative field (HA0 record), the primary insurance company's name, the amount allowed, the amount paid, and any deductible information.

Note: Keep the narrative in the HA0 Record as brief and as concise as possible while supplying all the necessary information.

HCPCS Code Inquiries

The Statistical Analysis DME Regional Carrier (SADMERC) HCPCS Helpline provides assistance in determining the appropriate HCPCS code to use for particular DMEPOS items. The following is a list of frequent HCPCS code inquiries to the SADMERC. The SADMERC - Palmetto Government Benefits Administrators in South Carolina - can be reached at (803) 736-6809, from 9 a.m. to 12:00 p.m. and 1:00 p.m. to 4:00 p.m., Eastern Standard Time.

XX058	Vivonex TEN
XX033	Glucerna
B4150	Promote
A4565	Arm Sling
E0935	Continuous Passive Motion Device
E0943	Cervical Pillow
A4554	Disposable Underpads, Adult Undergarment, Adult Diapers
E1300	Portable Whirlpool
J7699	Atrovent Inhalation Solution, with description and dosage
K0183	CPAP Mask
L0515	Abdominal Surgical Support / Elastic with Rigid Back Panel
L4350	Ankle Aircast
L8220	Elastic Compression Stocking (refer to range of L8100 through L8230 for complete stocking codes)
00015-3091-45	Etoposide 50 mg
E0244	Elevated Toilet Seat
E0243	Toilet Rails
B4150	Jevity
L2112	AFO (Ankle-Foot-Othosis) Tibial Fracture "CAM" Walker, *soft*, custom fitted
L2114	AFO (Ankle-Foot-Othosis) Tibial Fracture "CAM" Walker, *semi-rigid*, custom fitted
L3260	Ambulatory Post-Op Surgical Shoe
L3908	Non-molded Wrist Splint with Velcro Straps
Q9920 - Q9940	EPO (Epoetin Alpha). Note: You must know the patient's last Hematocrit (HCT to correctly select the appropriate Q code.

Examples:

Q9920 - Injection of EPO, per 1000 units, at patient HCT of 20 or less.

Q9933 - Injection of EPO, per 1000 units, at patient HCT of 33.

PEN Billing

Some PEN suppliers are submitting claims with an NSC number on the HCFA-1500 form which is different from the NSC number on the previously submitted CMN. In order to process any future claims for these services, the same NSC number must appear on the initial claim and on all grandfathered claims. Any claims received with an NSC number different from the initial or grandfathered claim will be denied with Action Code 307.

Additionally, if a CMN is submitted and the required information is not answered (for example, questions, signatures, height and weight), the claim will be denied with Action Code 348.

Note: Question No. 6 on CMN 10.01 needs to be answered with a Y or N.

Reminder to PEN Suppliers

Suppliers must indicate on the claim if a beneficiary has changed suppliers and the date of the change. This includes both paper and EMC claims.

When submitting an initial or recert on PEN recertifications, make sure the cert is complete (weight, height, and all questions answered).

Pricing

Revised 1994 DME Fee Schedules - Capped Rental Items

Rental	CT	ME	MA	NH	RI	VT	NY	NJ	PA	DE
K0001	$ 42.46	$ 48.00	$ 48.00	$ 45.06	$ 48.00	$ 40.80	$ 45.32	$ 46.13	$ 48.00	$ 48.00
K0002	$ 68.20	$ 68.38	$ 66.44	$ 62.74	$ 61.12	$ 65.56	$ 71.54	$ 71.91	$ 71.91	$ 71.91
K0003	$ 78.74	$ 78.74	$ 78.74	$ 78.00	$ 66.93	$ 78.74	$ 70.51	$ 78.74	$ 78.74	$ 66.93
K0004	$ 100.22	$ 117.45	$ 117.45	$ 112.34	$ 117.45	$ 117.45	$ 117.45	$ 100.30	$ 112.86	$ 99.83
K0006	$ 110.21	$ 110.21	$ 110.21	$ 110.21	$ 93.68	$ 110.21	$ 110.21	$ 107.56	$ 110.21	$ 93.68
K0010	$ 374.39	$ 374.39	$ 374.39	$ 374.39	$ 318.23	$ 374.39	$ 318.23	$ 318.23	$318.51	$ 321.18
K0101	$ 38.35	$ 32.88	$ 32.60	$ 32.60	$ 32.60	$ 32.60	$ 38.10	$ 37.27	$ 38.15	$ 38.35

K0110, K0111, K0131, K0164

DME fee schedules for codes K0110, K0111, K0131, and K0164 have been calculated as follows:

	K0110	K0111	K0131	K0164
Connecticut	$ 19.89	$ 41.07	$ 15.85	$ 3.29
Delaware	$ 19.89	$ 41.07	$ 15.85	$ 3.22
Maine	$ 19.89	$ 41.07	$ 15.85	$ 3.29
Massachusetts	$ 19.89	$ 41.07	$ 15.85	$ 3.29
New Hampshire	$ 19.89	$ 41.07	$ 15.85	$ 3.22
New Jersey	$ 19.89	$ 41.07	$ 15.85	$ 3.22
New York	$ 19.89	$ 41.07	$ 15.85	$ 3.22
Pennsylvania	$ 19.89	$ 41.07	$ 15.85	$ 3.22
Rhode Island	$ 19.89	$ 41.07	$ 15.85	$ 3.22
Vermont	$ 19.89	$ 41.07	$ 15.85	$ 3.29

E0935

The fee schedule for code E0935 has been converted to a per diem fee schedule and is listed below.

Connecticut	$ 19.98
Delaware	$ 19.98
Maine	$ 19.98
Massachusetts	$ 19.98
New Hampshire	$ 19.98
New Jersey	$ 19.98
New York	$ 16.98
Pennsylvania	$ 19.98
Rhode Island	$ 16.98
Vermont	$ 19.98

Post-Transition Workshops

The Travelers Region A DMERC is holding Post-Transition Workshops throughout Region A. The workshop schedule is shown below.

Two workshops will be held per day. For the morning sessions, registration will be at 7:30 A.M., and the presentation will be held from 8:00 A.M. to 11 :30 A.M. For the afternoon sessions, registration will be at 12:30 P.M., and the presentation will be held from 1:00 P.M. to 4:30 P.M.

The workshops address issues suppliers have encountered in transitioning from local to regional carriers. Each workshop features a discussion on topics such as Electronic Media Claims, Claims Submission (including examples) and Medical Policy, along with a Questions and Answers session. Please bring the following materials to the workshop: DMERC Region A *Supplier Manual*, HCFA-1500 Form, National Supplier Clearinghouse Number, and writing materials.

State	City	Meeting Site		Date of Seminar	Date of Transition
MA	Boston	Boston/Newton Marriott, Commonwealth Ave. at Route 128 and Massachusetts Turnpike	(617) 969-1000	10/10/94	07/01/94
	Springfield	Marriott Hotel, Boland Way & Columbus Avenue	(413) 781-7111	10/12/94	

Post-Transition Workshop Registration Form

NAME: ______________________________

REPRESENTING: ______________________________

ADDRESS: ______________________________

____

PHONE NUMBER: ____________ NSC NUMBER *(required to attend)* ____________

CHECK THE SUPPLIER TYPE: ❑ DME ❑ O&P ❑ OXYGEN ❑ PEN ❑ OTHER

SPECIALTY: ______________________________

WORKSHOP DATE AND LOCATION: ______________________________

SESSION: ❑ A.M. ❑ P.M. NUMBER ATTENDING: ____________ *(maximum 4)*

PLEASE COMPLETE THIS FORM AND MAIL OR FAX TO:

MAIL TO: THE TRAVELERS REGION A DMERC
P. O. Box 6800
WILKES-BARRE, PA 18773-6800

FAX TO: PROFESSIONAL RELATIONS
(717) 735-9402

✂ -
(Cut here)

Crossover

Complementary Insurers

The following is a list of Complementary insurers with the Region A DMERC which accept participating/assigned and non-participating/non-assigned claims:

❑ AARP/Prudential	18936A001
❑ APWU (American Postal Workers Union)	20904A001
❑ Aetna	06457A001
❑ American General	37250A001
❑ American Republic	50301A001
❑ BC/BS Alabama	35244B001
❑ BC/BS Connecticut	06473C001
❑ BC/BS Delaware	19801B001
❑ BC/BS Michigan	48226B001
❑ BC/BS New York (West)	14240B001
❑ BC/BS Pennsylvania	17089B001
❑ BC/BS Rhode Island Plan 65	02903B001
❑ Mutual of Omaha	68131M001
❑ NALC (National Association of Letter Carriers)	22093N001
❑ Olympic Health Mgmt	98227O001
❑ The Hartford (ITT)	22312I001
❑ United American	75221U001

Note: Mutual of Omaha is listed in the *Supplier Manual* with an OCNA number of 68175M001. This is incorrect. The correct number is 68131M001.

New Hampshire Medicaid

New Hampshire Medicaid will be publishing the article below in their newsletter. The Travelers DMERC wanted to notify the supplier community of the procedures New Hampshire Medicaid would like suppliers to follow. The article below describes this procedure.

DMERC Crossovers

Crossover claims for durable medical equipment received by EDS on tape from The Travelers have not been and are not being currently processed electronically by EDS. DMERC claims must be submitted on paper to EDS. Please submit The Travelers EOMB with the provider name, Medicaid provider number, the recipient's Medicaid identification number, and the type of service written on the EOMB. Circle the recipient information (do not highlight).

New Hampshire Medicaid can process one control number per EOMB. With the change to The Travelers as the Regional DME Medicare processor, the National Supplier Clearinghouse (NSC) has assigned providers new NSC numbers. Consequently, significant systems changes will be required before EDS can process these crossover claims electronically. When the electronic crossover process is in place, providers will be notified.

AARP/Prudential

It has been determined that only Medicare Beneficiaries and Railroad Board Beneficiaries residing in Connecticut that are members of AARP / Prudential will appear on the eligibility file from AARP / Prudential. Therefore, Medicare DME claims, for the beneficiaries referred to above, from Participating / Non-Participating suppliers will be forwarded to AARP / Prudential.

Suppliers that are Participating and accept Assignment will need to complete the AARP / Prudential insurance information when submitting a claim for a beneficiary which resides in one of the other 9 states in order for crossover to occur.

The completion of Blocks 9 thru 9D of the HCFA 1500 form for paper submissions and secondary insurance information when submitting via EMC is necessary for crossover. Be sure to use the OCNA number 18936A002.

OCNA Number Change

In the Supplier Manual in Section 4 Page 36, the Department of Income Maintenance for Maine has an OCNA number of 04333D001. This number is incorrect and needs to be changed to 04330D001.

Claims Processing

HCPCS Code A4400 Not Valid

Procedure code A4400 - OSTOMY IRRIGATION SET, is no longer a valid code. Each item from the set needs to be billed separately. Use the following HCPCS codes for billing these items:

A4397 - Irrigation Sleeve
A4398 - Irrigation Bags
A4399 - Irrigation Cone / Catheter

To determine the correct allowable for these items please refer to the fee schedule in Chapter 6 of the *Supplier Manual*.

Billing for Surgical Dressings

Initial claims for surgical dressings submitted to the DMERC should contain documentation to indicate: the number of wound sites, the size of each site and location of each site. This information should be provided with all initial claims submitted and with any subsequent claims should the information change. This information is needed to properly adjudicate the claims.

Miscellaneous Codes

Miscellaneous codes or not otherwise classified codes require a complete description of the item that is being billed. Failure to furnish this information will cause a delay in payment or a denial.

Resubmittal vs. Review

When a claim is denied due to missing information (i.e lack of a Certificate of Medical Necessity, missing UPIN number or incorrect HIC number) the claim can be resubmitted with the additional or corrected information since no payment was made on the claim.

When a claim is denied due to a medical necessity reason or an incorrect number of service the claim has to be reviewed. When submitting claims for review, please be sure to specifically indicate exactly what is to be reviewed and why you feel the claim was processed incorrectly.

Billing for Orthotics/Prosthetic Devices in a Hospital

If the prosthesis / orthosis is provided to an inpatient in a hospital, the allowance for the device is included in the DRG payment made to the hospital. The evaluation, fitting, and dispensing are included in the allowance for the Prosthetic / Orthotic device. Mileage charges for travel are non-covered.

UPIN Number

All assigned EMC and paper claims received by The Travelers Region A DMERC must have the name and UPIN number of the referring / ordering physician on the claim. If the above information does not appear, the claim will be denied with action code 369.

Non-assigned claims submitted without the name and UPIN number of the referring / ordering physician will be developed. This will cause a delay in the processing of the claim.

Parenteral Nutrition Pump Codes

Suppliers providing parenteral nutrition pumps need to be using the correct B codes when billing for these items. The correct codes are:

- ❑ B9004 - Parenteral Nutrition Infusion Pump, portable
- ❑ B9006 - Parenteral Nutrition Infusion Pump, stationary

Many suppliers have been billing for parenteral nutrition pumps using HCPCS codes E0781 and E0791. These codes are only to be used when billing for infusion pumps used for the delivery of prescription medications. They should not be used for billing the parenteral nutrition pumps. In addition, when billing for Parenteral/Enteral nutrients, the "FROM" date and "TO" date must be reported. This information is required to properly adjudicate the claim.

Prior Authorization

At this time, the DMERC is only to prior authorize POV (E1230), seat Lift Mechanism (E0267-E0269), and TENS Unit purchase. The Region A DMERC can not prior authorize any other item, such as Custom Wheelchairs.

Reminder: HCPCS code E0620 (Seat Lift Mechanism) is not a valid code to be submitted to the DMERC. Use of this code will cause delay in payment or development of the claim. Please use E0627-E0629. These items must have a written order prior to delivery.

Place of Service

The Region A DMERC is receiving claims that indicate 99 as the Place of Service, causing a delay in the processing of claims. To avoid processing delays, indicate the correct Place of Service code depending upon where the patient is using the equipment.

Coverage under the durable medical equipment benefit does not extend to beneficiaries who are in a hospital or skilled nursing facility. Place of Service code 31 (Skilled Nursing Facility) or code 32 are not billable to the DMERC for durable medical equipment items. Durable medical equipment is covered in place of service 33 (Custodial Care) or 12 (Home). This includes facilities that provide room and board, but does not include a medical component.

For a complete list of Place of Service codes, refer to pages 4-14 through 4-16 of the Region A *Supplier Manual*.

Wheelchair Codes

The following examples address the different situations that apply when billing wheelchair codes to the DMERC:

1. Rental payments were made by the local carrier for code E1130RR. Suppliers must continue to submit claims using E1130RR with the correct "K" code modifier until the end of the cap rental period. Also, all maintenance and service charges should be billed using this code.

2. The rental of the wheelchair began before the transition, but the supplier never billed the local carrier. This requires the use of the appropriate K code with the RR and KH modifier.

3. The rental starts after the transition to the Region A DMERC. This requires the use of the appropriate K code with the RR and KH modifier.

Health Insurance Claim Number

A valid and correct Health Insurance Claim (HIC) number must be present in Block 1A of the HCFA-1500 form. The HIC number is the primary identifier on the HCFA-1500 form, and if missing or invalid, will cause the processing of that particular claim to be delayed or potentially stopped. Searches of three databases are conducted for all claims, both assigned and non-assigned. These searches require the complete name and address of the beneficiary. If those searches are not successful due to an invalid or missing HIC number, the following procedures are followed.

Non-assigned claims, both paper and EMC are forwarded to the Telephone Investigation Unit where calls to the supplier and/or beneficiary are made to obtain the correct HIC. This can be time-consuming as the correct telephone numbers and the appropriate contact person are not always readily available. If the appropriate contact person is not available, more time is lost waiting for a return phone call. After an unsuccessful attempt at obtaining the HIC number by telephone, the claim is returned to the supplier for resubmittal with the correct information.

Assigned paper and EMC claims are not investigated and will be returned to the supplier to be resubmitted with the correct HIC number.

Reminder: HIC numbers can be identified from the beneficiary's red, white, and blue Medicare card issued by the Railroad Board or the Social Security Department.

Billing Reminders

When submitting claims to the Region A DMERC be sure that all appropriate information is included on the claim and, if applicable, on the CMN. Remember to:

- ❑ Enter the correct number of services on the claim.
- ❑ Include descriptions of Not Otherwise Classified (NOC) codes.
- ❑ Use correct modifiers.
- ❑ Include the correct UPIN number on the claim.

❑ Use the correct supplier number.

❑ Answer required CMN questions.

❑ Enter the correct place of service code.

Information on the CMN and HCFA-1500 form may be typed or hand-written. If hand-written, be sure it is legible.

Miscellaneous

National Supplier Clearinghouse

On August 1, 1994, the National Supplier Clearinghouse (NSC) toll-free line (800-851-3682) was discontinued. Suppliers can reach an NSC representative by calling (803) 754-3951.

Flu Vaccine Offer

The Health Care Financing Administration (HCFA) is urging all individuals and entities meeting state licensure requirements to make a special effort during the upcoming flu season to offer the influenza virus vaccination to individuals enrolled in Part B of the Medicare program. For coverage purposes, Medicare does not require that the vaccine be ordered by a doctor of medicine or osteopathy; therefore, a beneficiary may receive the vaccine upon request without a physician's order and without physician supervision if authorized by state law. Medicare generally will pay for only one flu shot per flu season.

Part B reimburses the influenza vaccine and its administration at 100 percent of the Medicare allowed charge. The Part B deductible and coinsurance do not apply to these charges. When scheduling beneficiaries for their flu shots, please check to ensure that they are enrolled in Part B of the Medicare program and have not already received the flu vaccination in another setting during the last 12 months.

Non-participating physicians and suppliers are not required to accept assignment when billing Medicare for the influenza virus vaccination and/or its administration when using standard billing procedures. We remind you that entities which undertake mass immunization programs may be eligible to use a "simplified" billing process, provided they accept assignment as a qualifying condition.

Call the Region A DMERC at 800-842-2052 for additional information about any aspect of the Medicare influenza virus vaccination benefit.

FDA Quality Testing of Oxygen

An Alert to Suppliers

The Food and Drug Administration (FDA) is now advising HCFA when a supplier fails to meet minimal quality and standards. Failure to meet FDA standards may adversely affect Medicare reimbursement.

Newsletter Corrections

The June edition of *DME Medicare News* ("Hints for Completing the HCFA-1500 Form," page 26) states that **Block 31** of the HCFA-1500 form must be completed with the provider's name and address. This statement is incorrect. **Block 33** should contain this information, along with the provider's 10-digit NSC number.

The June edition of DME Medicare News (Nebulizers, page 21) contains two errors. The corrections are as follows:

A4323 Saline Solution unit dosage per 1,000 ml
$7.71 per 1,000 ml

XX001 Saline Solution unit dosage per 3 ml or 5 ml:
$.09 per unit dose

Supplier Manual Corrections

1. The following is a change to the Medical Policy section of the *Supplier Manual* (page 13-46, Revision 003, March 1994), "Continuous Positive Airway Pressure System (CPAP)," *Coverage and Payment Rules*:

   While in most cases we do *not* allow separate reimbursement for accessories of DME which the beneficiary is renting, there are now exceptions to this rule. In the case of nebulizers and CPAP devices, we will allow separate reimbursement for accessories used in these devices. The policy on CPAP will be revised in the next *Supplier Manual* update.

2. The time limit for a request for a fair hearing is 180 days, not 120 days as stated in the *Supplier Manual.* Please make this correction to your manual (page 8-5, "Time Limits and Monetary Thresholds").