Special Edition

DME Medicare News

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

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New Provider Remittance Notice

The Health Care Financing Administration (HCFA), which administers the Medicare program, is making a number of changes in the payment notices sent to physicians, practitioners and suppliers. As part of HCFA's continuing effort to eliminate any variations in the administration of Medicare across the States and to furnish a uniform level of information to all providers of health care about the decisions made on their claims, the look and content of paper remittance advice notices is being standardized. Remittance notices are also known as Medicare Summary Vouchers.

Contacts

DME Region A Service Office
The MetraHealth Insurance Co. . . . . (717) 735-9400
FAX . . . . . (717) 735-9402

Beneficiary Toll-Free Number . . . . . (800) 842-2052

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 Help Line Number . . . . . (717) 735-9445

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

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Reason Codes and Medicare-Specific Remarks Codes and Messages

Reason codes, and the text messages that define those codes, are used to explain why a claim may not have been paid in full. For instance, there are reason codes to indicate that a particular service is never covered by Medicare, that a benefit maximum has been reached, to identify non-payable charges which exceed the fee schedule, or a psychiatric reduction. Under the standard format, only reason codes approved by the American National Standards Institute (ANSI) X12.835 Insurance Subcommittee and Medicare-specific supplemental messages approved by HCFA may be used.

ANSI is a non-governmental private association, of which HCFA is a member, that sets national standards for not only health care transactions but also for banking, transportation, electrical appliances, and a very wide range of items and services that affect all Americans. The ANSI X12.835 reason code messages are expected to become the standard for use by all health payers in the United States.

The X12.835 reason codes were designed to replace the large number of different coding systems used by health payers in this country, and to relieve the burden on medical providers to interpret each of the different coding systems. The ANSI X12.835 messages have already been implemented for Medicare electronic remittance advice transactions and are now being extended to our paper notices for both Medicare Part A and Part B claims. As the standard X12.835 reason messages were developed as generic messages to be used by all national health payers, few are specific to Medicare. With the con-

currence of ANSI X12.835, HCFA has supplemented the generic reason codes and messages with appeals and developmental codes and messages specific to Medicare. Although reason codes and HCFA message codes will appear in the body of the remittance notice, the text of each code that is used will be printed at the end of the notice to facilitate interpretation. The approximately 10,000 different messages used by Medicare carriers nationwide have been reduced to fewer than 400 messages. The standard messages may expand or change occasionally as the need arises, but HCFA plans to limit the frequency of such changes.

The messages may not be as detailed as some messages you received in the past, but they were considered to be equivalent and adequate for their business needs by the provider and health payer representatives who participated in development and subsequently reviewed those codes and messages for ANSI X12.835.

Due to differences in terminology among provider types, and in the pursuit of simplification, ANSI X12.835 issued two provisos to keep in mind when you interpret their messages. Any references to procedures or services in the reason codes apply equally to products, drugs or equipment, and references to prescriptions also include certificates of medical necessity. Beyond that, the messages should be self-explanatory.

As standard codes and messages are not customized to report the identity of any third party payer or alternate carrier to whom your claims may have been transferred for processing, whenever the ANSI X12.835 message, "The claim has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor." or the HCFA remark message, "The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them." is used, Medicare will also identify that other payer or carrier, DME carrier or Railroad office to whom the data was sent.

Group Codes

An ANSI X12.835 group code will always be shown with a reason code to indicate when you may, or may not, bill a beneficiary for the non-paid balance of the services or equipment you furnished. This corresponds to payment information already being sent to beneficiaries in their Explanation of Medicare Benefits.

All denials or reductions from your billed amount with a group code of PR (patient responsibility) are the financial responsibility of the beneficiary or his / her supplemental insurer (if it covers that service). Due to their frequency of use, separate columns have been set aside for reporting of deductible and coinsurance, both of which are also patient responsibility. PR amounts, including the deductible and coinsurance, are totaled in the Patient Responsibility field at the end of each claim. If you already collected an amount from a beneficiary for this claim in excess of the Patient Responsibility total prior to receipt of the remittance notice, you are required by law to refund that excess to the beneficiary.

You may not hold a beneficiary financially responsible for any adjustments identified with a group code CO (contractual obligation). CO is always used to identify excess amounts for which the law prohibits Medicare payment and absolves the beneficiary of any financial liability, such as participation agreement violation amounts, limiting charge violations, late filing penalties, or amounts for services not considered to be reasonable and necessary.

Group code OA (other adjustment) will be used when neither PR or CO applies, such as with reason code message that indicates the bill is being paid in full. A final group code, CR (correction or reversal to a prior decision), will be used whenever there is a change to the decision on a previously adjudicated claim, perhaps as a result of a subsequent reopening. CR explains the reason for a change and would always be used in tandem with PR, CO, or OA to show revised information.

Transition to the Standard Format

In some cases, the new remittance notice format may supply you with more detail than previously received from your local carrier. Each carrier was previously allowed to design its own format to report remittance notice information. If you practice in more than one State or interact with more than one carrier, you will now only have to deal with one format rather than a different format for each carrier. With implementation of the new format, the payment information in the paper and electronic remittance notices will be identical.

For those providers who may have resisted converting to electronic remittance advice transactions because it may have been more comfortable to continue to use the familiar local paper format, this may be a good time to investigate receipt of electronic remittance advice transactions to complement your electronic claims submission and reduce the volume of paper you receive. Your carrier electronic claims representative will be happy to discuss with you, and to offer you software that will help you receive it. This software is available either free or at a cost that may not exceed the carrier's cost for copying and sending.

Many carriers may still be using preprinted paper stock with appeal rights on the rear at the onset of the new remittance notices. Carriers will also begin to send information remittance notices to nonparticipating physicians concurrent with this change in the remittance notices. As they will be reminded in their claim messages, the preprinted appeal rights do not apply to nonparticipating physicians unless the claim involved a denial un-

der section 1862 (a)(1) of the Social Security Act for services not considered reasonable and necessary for the beneficiary's care.

To help those providers who balance their billed amounts against the Medicare payments and adjustments, paid and adjusted amounts will be totaled at the end of the assigned claims listings. Information on any unassigned claims will be listed separately after the assigned claims to avoid any inadvertent use of the unassigned claims information, for which Medicare payment is not issued to a provider, to balance accounts.

In a change for some providers, offset to payments, perhaps for a prior Medicare overpayment, will be shown as an adjustment from your payment at the summary level rather than as an adjustment against an individual claim in that remittance notice. As individual claims in the remittance notice would not have contributed toward the overpayment being collected, ANSI advised and HCFA concurs, that such withholding should be shown at the provider summary level. The Financial Control Numbers (FCNs), that will enable you to associate the offset with those claims and payments that led to the withholding or to identify the reason for the offset will still be shown.

In some areas of the country, providers were furnished copies of the beneficiary Explanation of Medicare Benefits (EOMB) in addition to a Medicare Remittance Notice. The standard remittance notice format and messages will now provide all data in the EOMB, except for any interest payment issued the beneficiary, and will supplant the EOMB for provider internal use or for billing of other payers. If you have a particular need for a beneficiary EOMB or a duplicate remittance notice, you may request one on an individual basis, but EOMBs will no longer be routinely mailed to providers.

Abbreviations

To make the most efficient use of space, a number of abbreviations are used in the new remittance advice. You may be familiar with most of them already, but the following key is provided to dispel any confusion.

ACNT	Patient account # assigned by the provider
ADJS	Adjustments
ALLOWED	Allowed amount (prior to deductions or offsets
ASG	Whether assignment accepted (Y or N)
BILLED	Billed amount
COINS	Coinsurance due
DEDUCT	Deductible due
FCN	Financial control number of prior claims that contributed to the overpayment or that explains the reason for the offset
HIC	Medicare health insurance claim number
ICN	Internal control number (also known as DCN)
INT	Interest
MOA	Medicare outpatient adjudication remark code
MODS	HCPCS modifiers
MSP	Amount paid by an insurer primary to Medicare
NOS	Number of services
OTHER	Other claim level adjustments that apply
PD TO BENE	Amount paid to beneficiary for this claim
POS	Place of service
PREV PD	Previous payment on this claim
PROC	HCPCS / procedure code (If different, the billed HCPCS will be printed under the paid HCPCS)
PROV PD	Paid to provider
PT RESP	Patient responsibility
RC AMT	Adjustment reason code other than deductible and coinsurance. If more than one, additional adjustment codes and amounts will appear on the next line.
REM	Remarks codes
SERV DATE	Date of service

Summary

HCFA has tried to respond to provider requests for simplification, standardization, and fewer pieces of paper. HCFA hopes this revision responds to those requests while continuing to provide you with the information you need to understand the decisions made on your claims.

SAMPLE OF REMITTANCE NOTICE PAGES 1, 2, and 3

Region A Workshops "Back to Basics"

The Region A DMERC has developed a series of workshops titled "Back to Basics." These interactive sessions will enable providers to increase their understanding of DMEPOS billing procedures. DMERC representatives from Professional Relations and the Medical Unit will be conducting the workshops. The workshop agenda will consist of the following:

8:00 a.m. - 8:30 a.m. Registration (continental breakfast)
8:30 a.m. - 10:15 a.m. Life of a Claim *****
10:30 a.m. - 12:00 p.m. Action Code Interpretation (EOMB Messages)
12:00 p.m. - 1:30 p.m. Lunch (provided)
1:30 p.m. - 3:15 p.m. HCFA 1500 Form/Related Electronic Fields, CMN Updates, You and Your Provider Manual, Fraud and Abuse
3:30 p.m. - 4:00 p.m. EMC Updates/Accelerate
4:00 p.m. - 5:00 p.m. Miscellaneous Updates/Q&A

***** Learn how your claim travels through the DMERC processing system. You will gain an understanding of claim status interpretation and learn how to track your claim through its processing journey.

To Register:

Please complete and mail the registration form below along with your registration fee of $25.00 per person (**check only** - made payable to MetraHealth Insurance Company) to:

MetraHealth - Region A DMERC
Attention: Seminar Registration
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

Your registration form and payment must be **received two (2) weeks prior** to the workshop you wish to attend. Electronic submitters will receive a confirmation via the bulletin board. Paper submitters will receive a confirmation via fax or mail. It is not necessary to call to verify your registration. Due to limited space, registration is required and **will not** be accepted at the door the day of the workshop. In addition, the registration fee is non-refundable. Workshop materials will be provided, along with a continental breakfast and deli lunch.

Please note: The DMERC reserves the right to cancel any workshop based on low attendance or inclement weather. In either instance, your registration fee will be refunded.

Date	City/State	Location	Phone
March 6	Monroeville, PA	Radisson Hotel, 101 Mall Blvd.	412-373-7300
March 8	Cherry Hill, NJ	Holiday Inn, Rt 70 & Sayer Ave.	609-663-5300
March 11	White Haven, PA	Mountain Laurel Resort, I-80 at PA Turnpike	717-443-8411
March 13	Cromwell, CT	Holiday Inn, 4 Sebethe Drive	203-635-1001
March 15	New York City, NY	Holiday Inn Crown Plaza, 104-04 Ditmars Blvd.	718-457-6300
March 18	Rochester, NY	Holiday Inn Airport, 911 Brooks Ave.	716-328-6000
March 20	Albany, NY	Holiday Inn, 205 Wolf Road	518-458-7250
March 22	Burlington, VT	Ramada Inn, 1117 Williston Road	802-658-0250
March 25	Augusta, ME	Holiday Inn, 110 Community Drive	207-622-4751
March 28	Bedford, NH	Sheraton Tara, 121 South River Road	603-622-3766
March 29	Milford, MA	Sheraton Inn, 11 Beaver Street	508-478-7010

" @WORKSHP TABS =

(Cut Here)

REGISTRATION FORM

Company Name: _____ Provider/Submitter No.: _____

Address: _____

Name(s) of person(s) attending: _____

Phone No.: _____ Fax No. _____

Date & City of workshop you wish to attend: _____

Payment Information: _____ Number of persons attending
x $25.00 per person
_____ Total Amount Enclosed