DMERC
Medicare
News

DMERC Region A Service Office • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800 • Phone (717) 735-9445

Change in Processing Systems

The Region A DMERC would like to inform the supplier community of a Health Care Financing Administration (HCFA) directed change in processing systems.

Region A will transition to theVIPS Medicare System (VMS). VIPS is the processing system utilized by the other Durable Medical Equipment Regional Carriers.

The DMERC will continue to work closely with HCFA to ensure a smooth transition from our current system to VMS.

As part of the transition, the DMERC is in the process of developing an outreach program to educate those that would be affected by this change. This will include educational seminars.

Suppliers have begun to generate questions to the DMERC regarding this transition and the DMERC will continue to provide updates as we proceed with implementation of VMS. Further information on this topic will be distributed in upcoming newsletters, supplier notices, on the automated response unit (ARU) and the electronic bulletin board (BBS).

PLEASE NOTE: Region A previously published a "Supplier Alert" dated, September 19, 1997, announcing that we will transition to the VIPS processing system. There has been a change in the date of transition. *We will not transition on April 1, 1998 as published.* The DMERC will notify the supplier community of the transition date once it is confirmed. Educational seminars will be planned in accordance with the revised transition date.

Ask the Doc

In the next issue of the DMERC Medicare News we will be introducing a column entitled, "Ask the Doc?". This column will consist of questions and answers regarding Medical Policy. Our Medical Director, Dr. Paul Hughes, will host this new feature.

If you have an issue which you would like addressed, please send it to:

United HealthCare
Region A DMERC
Attn.: Editor - DMERC
Medicare News
PO Box 6800
Wilkes-Barre, PA 18773-6800

DMERCs Attend Medtrade Show

The four Durable Medical Equipment Regional Carriers (DMERCs) attended the Medtrade show that was held October 7-10 in New Orleans, LA. The DMERCs once again shared exhibit space. This joint effort by the DMERCs gave suppliers an opportunity to interact with all four DMERCs in one location. Our experience at the show was positive. The majority of suppliers, manufacturers and other healthcare professionals were very pleased with the DMERCs attendence. The DMERCs recognize these functions as an ideal opportunity to offer continued availability to suppliers.

IN THIS ISSUE

Medical Policy

Nebulizer Equipment Codes: No Products

In the March 1997, DME Medicare Newsletter (page 7) , the article "Proposed Nebulizer Equipment Coding Guide," requested that manufacturers submit to the SADMERC those nebulizer compressors and their technical specifications which they believed should be coded as either **E0565**, **K0269**, or **K0501**.

- E0565 is a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow rate of 6-8 liters / minute, and is capable of continuous operation
- K0269 is a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow rate of 6-8 liters / minute, but is capable only of intermittent operation.
- K0501 is a portable compressor which delivers a fixed, low pressure and is used with a small volume nebulizer. It must have battery or DC power capability and may have an AC power option.

The SADMERC reports having received no product descriptions in response to this article. Therefore, the DMERC concludes that there are no products that meet these descriptions. Thus, for dates of service on or after 4/1/98 claims for any of these three codes will be rejected as invalid for submission to the DMERC.

Blood Glucose Monitors - Policy Revision

A revision of the policy is included in the accompanying Supplier Manual Update. This revision clarifies which accessories are included in the allowance for the monitor. It also incorporates a code change from the 1997 HCPCS update.

This revision does not include expanded coverage for glucose monitors that is contained in the provisions of the Balanced Budget Act of 1997. Details of the possible expanded coverage are being addressed by HCFA and will be published when they are available. It is important to continue to add the ZX modifier to codes for the monitor, accessories, and supplies, but only when the order indicates that the patient is a diabetic and is being treated with insulin injections.

Extra Wide/ Heavy Duty Hospital Beds

Standard hospital beds are billed with codes E0250-E0266 or E0290-E0297. Hospital beds with a mattress that is wider than 36" and that can support a patient weighing more than 350 pounds must be submitted using miscellaneous code E1399. Initial claims for this type bed must be accompanied by: 1) a Hospital Bed CMN which must include the patient's weight and height, 2) the manufacturer and model / product name / number of the bed, and 3) any additional information which documents the medical necessity for the bed (e.g., reasons why a standard hospital bed is not adequate, etc.). Items 2 and 3 must be entered in the HA0 record of an electronic claim or attached to a paper claim. These beds will be considered capped rental items and therefore payment will only be made on a rental basis. The appropriate modifier (KH, KI, or KJ) must be used and the rent / purchase option must be offered in the tenth rental month, as with all capped rental items.

Infusion Pumps / Change of Drug

If the beneficiary begins using an infusion pump for one drug and subsequently the drug is changed or another drug is added, a revised Certificate of Medical Necessity (CMN) must be submitted for use of the pump with the new or additional drug.

Backup Equipment

Backup medical equipment is defined as an identical or similar device that is used to meet the same medical need for the patient but is provided for precautionary reasons to deal with an emergency in which the primary piece of equipment malfunctions. Medicare does not pay separately or make an additional payment for backup equipment.

When a determination is made that if a particular piece of equipment breaks down or malfunctions it will result in immediate life threatening consequences for the patient, Medicare will place that item in the frequent and substantial servicing payment category. For items in this payment category, the supplier receives monthly rental payments for as long as the equipment is medically necessary. However, the supplier is responsible for ensuring that there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment. The expectation is that an acceptable plan would involve input from the patient and the treating physician, and would take into account the severity of the patient's condition and time restraints in providing emergency support. This means that the supplier is responsible for ensuring that the patient's medical needs for the use of this equipment will be met on a continuous and ongoing basis and that there is a plan to deal with any interruptions in the use of the equipment that would be life threatening to the patient. The plan may be as simple as the supplier furnishing backup equipment. However, Medicare will not pay separately and / or make any additional payment for the backup equipment. The payment for the primary piece of equipment would include the cost of that piece of equipment and the frequent and substantial servicing plan that the supplier must provide to ensure that the patient always has a piece of equipment that is in working order. If the backup equipment is billed, it will be denied as not being reasonable and necessary.

Backup equipment must be distinguished from multiple medically necessary items which are defined as identical or similar devices each of which meets a different medical need for the patient. Though Medicare does not pay separately for backup equipment, Medicare will make separate payment for a second piece of equipment if it is required to serve a different purpose that is determined by the patient's medical needs. Examples (not all-inclusive) of situations in which multiple equipment may be covered are:

1. A patient requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g., positive pressure ventilator with a nasal mask) during the rest of the day.

2. A patient who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without both pieces of equipment the patient may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

3. A patient requires one type of infusion pump for a particular drug (e.g., a pump with patient control features for parenteral morphine) and needs a different type of pump for another drug (e.g., continuous infusion chemotherapy).

Examples (not all-inclusive) of situations in which a second or other multiple piece of equipment would be considered a backup and therefore would not be covered are:

1. A ventilator dependent patient is confined to bed and a second ventilator of the same or similar type is provided at the bedside as a precaution in case of malfunction of the primary ventilator.

2. The drug epoprostenol (Flolan) is administered using an ambulatory infusion pump and a second infusion pump is provided as a precaution in case of malfunction of the primary pump. (Because interruption of a continuous infusion of this drug results in immediate life threatening consequences, a unique code will be established for an infusion pump used to administer this drug and the code will be placed in the frequent and substantial servicing payment category.)

Epoetin

Coverage Reminder

Criteria for coverage of epoetin (EPO) (HCPCS codes Q9920-Q9940) claims submitted to the DMERC include requirements that:

1. the patient must be on dialysis that is reimbursed under the Method II selection, and

2. the EPO must be supplied by the supplier who provides the patient's dialysis supplies under Method II.

A beneficiary who chooses Method II deals directly with a supplier of home dialysis equipment and supplies that is not a dialysis facility. There can only be one supplier per beneficiary and the supplier must accept assignment of Medicare benefits for dialysis equipment and supplies. Claims filed to the DMERC for patients who are not on dialysis or are on Method I dialysis (dialysis facility provides dialysis equipment and supplies and bills the Medicare Part A Intermediary), or are on Method II dialysis but the supplier providing the EPO is not the supplier providing the dialysis supplies and equipment will be denied as noncovered.

Changes in Coverage

Effective for claims with dates of service on or after February 1, 1998, the policy for epoetin (EPO) has changed for dialysis patients. Hematocrit testing must be performed at least on a monthly basis. If the patient's reported hematocrit is 37% or greater (Q9937-Q9940) and the 90 day rolling average hematocrit measurement is 36.5% or greater, the claim will be denied as not medically necessary.

Dialysis patients with symptomatic anemia considered for EPO therapy should be treated until the hematocrit reaches a target range of 30-36%. As the hematocrit approaches 36%, administration of EPO should be reduced temporarily. The dosage of EPO required to maintain target hematocrit levels is subject to individual patient variation and should be titrated according to patient response, with a goal of not exceeding a hematocrit level of 36%.

If the reported hematocrit level is 37% or greater, coverage for EPO will be based on a 90 day rolling average hematocrit measurement. If the posted claim history is for a period less than 90 days, the average hematocrit level will be calculated based upon the history for that time period. If claims are submitted out of chronological order, the average hematocrit level will be calculated based on claims for services furnished 90 days before the claim was submitted.

If the rolling average hematocrit measurement is less than 36.5%, the EPO on the billed claim will be allowed. If the rolling average hematocrit measurement is 36.5% or greater, the claim will be denied as not medically necessary.

For beneficiaries residing in altitudes at or above 6,000 feet, a rolling 90 day average of 39.5% or less will be allowed and averages exceeding 39.5% will be denied as not medically necessary.

(Epoetin continued)

Documentation

Claims submitted to the DMERC must include the proper HCPCS code (Q9920-Q9940) that accurately reflects the most recent hematocrit levels prior to the date of service on the claim (no earlier than 1 month prior to the date of service). Each claim must also include the date that test was performed. Report the date of the test with the hard copy claim or in the HA0 record, if submitting the claim electronically.

Refer to the Epoetin policy for additional information about coverage requirements, selecting the correct HCPCS code to indicate the patient's most recent hematocrit, the methodology for converting hemoglobin values to comparable hematocrit values for facilities that use hemoglobin instead of hematocrit to monitor red blood cells in patients with anemia, and additional documentation requirements.

Jaw Motion Devices

Jurisdiction Changes - E1700, E1701 and E1702

Effective for claims received on or after October 20, 1997, jurisdiction for the following HCPCS codes is changed to the DMERC:

E1700 - Jaw Motion Rehabilitation System

E1701 - Replacement Cushions for Jaw Motion Rehabilitation System, Package of 6

E1702 - Replacement Measuring Scales for Jaw Motion Rehabilitation System, Package of 200

These codes describe manual, hand held, single patient use devices.

A continuous passive motion (CPM) jaw motion device (electronically controlled) should be billed with HCPCS Code **E1399 - Durable Medical Equipment, miscellaneous.** As with all miscellaneous procedure codes, a description of the product (i.e. manufacturer, make, model number) must be submitted with the claim.

In accordance with national Medicare policy, jaw CPM devices will be denied as not medically necessary since coverage for CPM is limited to patients who have received a total knee replacement.

HCFA Common Procedure Coding System

Correct Code for "Introl" Bladder Neck Support Prosthesis

The Introl Bladder Neck Support Prosthesis manufactured by UroMed Corporation is a reusable ring-shaped vaginal insert made of silicone which is designed to treat stress urinary incontinence in women.

The fitting and insertion of the Introl device is performed in the physician's office and should be billed to the Local Carrier using the appropriate CPT code. Claims for this service are included in the professional service.

Once the patient has been properly fitted by the physician and instructed to use this device at home, claims should be submitted to the DMERC using **A4560 - Pessary** and **not** A4335 - Incontinence supply, miscellaneous. Introl devices provided in the physician's office after the evaluation, fitting, insertion and completion of patient education may be billed to the DMERC using place of service 12 (home).

New Codes Effective For Dates of Service On or After January 1, 1998

The following new codes are effective for dates of service on or after January 1, 1998. The fees for these new codes will be published in the March 1998 newsletter.

Code	Description
A4462	Abdominal Dressing Holder/Binder, each
E0371	Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
E0373	Nonpowered advanced pressure reducing mattress
E0855	Cervical traction equipment not requiring additional stand or frame
J1325	Injection, Epoprostenol, 0.5 mg
K0455	Infusion pump used for uninterupted administration of Epoprostenol
L0999	Addition to spinal orthosis, not otherwise specified
L1843	KO, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted
L0235	KAFO, Full plastic, static, prefabricated (pediatric size)

Code	Description
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame
L8039	Breast Prosthesis, not otherwise specified
L8239	Elastic support, not otherwise specified

The following codes were effective for dates of service on or after April 1, 1997:

Code	Description
K0501	Aerosol compressor, battery powered, for use with small volume nebulizer
K0503	Acetylcysteine, inhalation solution administered through DME, unit dose form, per gram
K0504	Albuterol, inhalation solution administered through DME, concentrated form, per milligram
K0505	Albuterol, inhalation solution administered through DME, unit dose form, per milligram
K0506	Atropine, inhalation solution administered through DME, concentrated form, per milligram
K0507	Atropine, inhalation solution administered through DME, unit dose form, per milligram
K0508	Bitolterol Mesylate, inhalation solution administered through DME, concentrated form, per milligram
K0509	Bitolterol Mesylate, inhalation solution administered through DME, unit dose form, per milligram
K0511	Cromolyn Sodium, inhalation solution administered through DME, unit dose form, per 10 milligrams
K0512	Dexamethasone, inhalation solution administered through DME, concentrated form, per milligram
K0513	Dexamethasone, inhalation solution administered through DME, unit dose form, per milligram
K0514	Dornase Alpha, inhalation solution adminstered through DME, unit dose form, per milligram
K0515	Glycopyrrolate, inhalation solution administered through DME, concentrated form , per milligram
K0516	Glycopyrrolate, inhalation solution administered through DME, unit dose form, per milligram
K0518	Ipratropium Bromide, inhalation solution administered through DME, unit dose form, per milligram

Code	Description
K0519	Isoetharine HCL, inhalation solution administered through DME, concentrated form, per milligram
K0520	Isoetharine HCL, inhalation solution administered through DME, unit dose form, per milligram
K0521	Isoproterenol HCL, inhalation solution administered through DME, concentrated form, per milligram
K0522	Isoproterenol HCL, inhalation solution administered through DME, unit dose form, per milligram
K0523	Metaproterenol Sulfate, inhalation solution administered through DME, concentrated form, per 10 milligrams
K0524	Metaproterenol Sulfate, inhalation solution administered through DME, unit dose form, per 10 milligrams
K0525	Terbutaline Sulfate, inhalation solution administered through DME, concentrated form, per milligram
K0526	Terbutaline Sulfate, inhalation solution administered through DME, unit dose form, per milligram
K0527	Triamcinolone, inhalation solution administered through DME, concentrated form, per milligram
K0528	Triamcinolone, inhalation solution administered through DME, unit dose form, per milligram
K0529	Sterile water or sterile saline, 1000 ml, used with large volume nebulizer
K0530	Nebulizer, durable, glass, or autoclavable plactic, bottle type, not used with oxgyen

The following modifiers were effective for dates of service on or after April 1, 1997:

Modifier	Description
KO	Single drug unit dose formulation
KP	First drug of a multiple drug unit dose formulation
KQ	Second or subsequent drug of a multiple drug unit dose formulation

The following code was effective for dates of service on or after January 1, 1997:

Code	Description
K0453	Injection, Amphotericin B, 50 mg

Deleted Codes

The following codes have been discontinued effective for dates of service on or after January 1, 1998:

Code	Description
J1625	Injection, Granisetron Hydrochloride, per 1 mg
J3005	Injection, Strontium-89 Chloride, per 10 ml
K0413	Non-powered, advanced pressure-reducing overlay for mattress, standard mattress length and width
K0414	Powered air overlay for mattress, standard mattress length and width
K0454	Non-powered, advanced pressure-reducing mattress

The following codes have been discontinued effective for dates of service on or after April 1, 1997:

Code	Description
K0140	Acetylcysteine, compounded, per mg, inhalation solution administered through DME
K0141	Albuterol Sulfate, compounded, per mg, inhalation solution administered through DME
K0142	Cromolyn Sodium, compounded, per mg, inhalation solution administered through DME
K0143	Isoetharine Hydrochloride, compounded, per mg, inhalation solution administered through DME
K0144	Isoproterenol Hydrochloride, compounded, per mg, inhalation solution administered through DME
K0145	Metaproterenol, compounded, per mg, inhalation solution administered through DME
K0146	Terbutaline, compounded, per mg, inhalation solution administered through DME

Modified 1998 HCPCS Codes

The descriptions for the following codes have been modified effective for dates of service on or after January 1, 1998. Changes to the code descriptors have been highlighted and / or indicated below:

Code	Descriptor
A4800	Heparin for dialysis and antidote, any strength, porcine or beef, up to 1000 units, 10-30 ml **(for parenteral use see B4216)**
A5113	Leg Strap; latex, **replacement only**, per set
A5114	Leg strap; foam or fabric, **replacement only**, per set
A6261	Wound Filler, **Gel/Paste, per fluid ounce, not elsewhere classified**

Code	Descriptor
A6262	Wound Filler, **Dry Form, per gram, not elsewhere classified**
A9270	Non-covered item or service
B4150	Enteral formulae; Category I: semi-synthetic intact protein / protein isolates, 100 calories = 1 unit **(Brand names removed)**
B4151	Enteral formulae; Category I: natural intact protein / protein isolates, 100 calories = 1 unit **(Brand names removed)**
B4152	Enteral formulae; Category II: intact protein / protein isolates, (calorically dense), 100 calories = 1 unit **(Brand names removed)**
B4153	Enteral Formulae; Category III: hydrolized protein / amino acids, 100 calories = 1 unit **(Brand names removed)**
B4154	Enteral Formulae; Category IV; Defined formula for special metabolic need, 100 calories = 1 unit **(Brand names removed)**
B4155	Enteral Formulae; Category V: Modular components (protein, carbohydrates, fat), 100 calories = 1 unit **(Brand names removed)**
B4156	Enteral Formulae; Category VI: Standardized nutrients, 100 calories = 1 unit **(Brand names removed)**
E0159	Brake attachment for wheeled walker, **replacement**, each
E0178	**Gel or Gel-like** pressure pad or cushion, nonpositioning
E0185	**Gel or Gel-like** pressure pad for mattress, **standard mattress length and width**
E0192	Low pressure and positioning equilization pad, **for wheelchair**
E0197	Air pressure pad for mattress, **standard mattress length and width**
E0198	Water pressure pad for mattress, **standard mattress length and width**
E0199	Dry pressure pad for mattress, **standard mattress length and width**
E0277	**Powered pressure reducing air mattress**
E0370	**Air pressure elevator for heel ("Pad" removed)**
J1561	Injection, immune globulin, intravenous, **500 mg ("Per" removed; brand names removed)**
J1562	**Injection**, immune globulin, intravenous, **5 gms ("Human" removed, 10% removed; brand names removed)**
J2820	Injection, Sargramostim (GM-CSF), **50 mg (Brand name removed)**
J9150	Daunorubucin, 10 mg **("HCL" removed, brand name removed)**
L1499	**Spinal Orthosis, not otherwise specified**
L2999	**Lower extremity orthosis, not otherwise specified**
L3999	**Upper limb orthosis, not otherwise specified**
L5999	**Lower extremity prosthesis, not otherwise specified**
L7499	**Upper extremity prosthesis, not otherwise specified**

Category IV and V Enteral Nutrients - HCPCS Coding

Effective for dates of service (DOS) on or after January 1, 1998, Local HCPCS codes XX030 - XX058 and XX073 - XX084 will be replaced by B4154 and codes XX059-XX072 will be replaced by B4155.

The "XX" codes will continue to be valid for dates of service **prior to** January 1, 1998, regardless of the date of claim receipt. The appropriate "B" code must be used for billing for dates of service **on or after** January 1, 1998. Only those products on the following list will be billed using B4154 or B4155. If a manufacturer or supplier thinks that another product meets the definition of either of these codes, they should contact the SADMERC at (803) 736-6809 for a coding determination. The SADMERC must issue a written determination approving the use of codes B4154 or B4155 before either may be used for a new product or a product not listed in the following table:

"B" Code	"XX" Code	Product
B4154	XX030	**ACCUPEP HPF**
B4154	XX031	**AMIN-AID**
B4154	XX032	**ENTERA OPD**
B4154	XX033	**GLUCERNA**
B4154	XX034	**HEPATIC AID**
B4154	XX035	**IMPACT**
B4154	XX036	**IMPACT WITH FIBER**
B4154	XX037	**IMMUN-AID**
B4154	XX038	**LIPISORB**
B4154	XX039	**NEPRO**
B4154	XX040	**REPLETE**
B4154	XX041	**REPLETE WITH FIBER**
B4154	XX042	**NUTRIHEP**
B4154	XX043	**NUTRIVENT**
B4154	XX044	**PEPTAMEN**
B4154	XX045	**PERATIVE**
B4154	XX046	**PREGESTIMIL**
B4154	XX047	**PROTAIN XL**
B4154	XX048	**PROVIDE**
B4154	XX049	**PULMOCARE**
B4154	XX050	**READILAN HN**
B4154	XX051	**SUPLENA**
B4154	XX052	**STRESSTEIN**
B4154	XX053	**TRAUMA-CAL**
B4154	XX055	**TRAVASORB HEPATIC**
B4154	XX056	**TRAVASORB MCT**

"B" Code	"XX" Code	Product
B4154	XX057	**TRAVASORB RENAL**
B4154	XX058	**VIVONEX T.E.N.**
B4155	XX059	**CASEC**
B4155	XX061	**ELEMENTRA**
B4155	XX062	**FIBRAD**
B4155	XX064	**MCT OIL**
B4155	XX065	**MICROLIPID**
B4155	XX066	**MODUCAL**
B4155	XX068	**POLYCOSE**
B4155	XX069	**PROMOD**
B4155	XX070	**PROMIX**
B4155	XX071	**PROPAC PLUS**
B4155	XX072	**SUMACAL**
B4154	XX073	**ADVERA**
B4154	XX074	**CRUCIAL**
B4154	XX075	**DIABETISOURCE**
B4154	XX076	**ISOSOURCE VHN**
B4154	XX077	**VIVONEX PLUS**
B4154	XX078	**SANDOSOURCE PEPTIDE**
B4154	XX079	**L-EMENTAL PLUS**
B4154	XX080	**PRO-PEPTIDE**
B4154	XX081	**PEPTAMEN VHP**
B4154	XX082	**IMPACT 1.5**

The following products are included on the approved list but do not have a corresponding "XX" code for dates of service prior to January 1, 1998:

"B" Code	"XX" Code	Product
B4154		Alitraq
B4154		Choice DM
B4154		Citrotein
B4154		Fulfill
B4154		L-Emental Hepatic
B4154		Peptamin Junior
B4154		Renalcal
B4154		SLD
B4155		ProCare

Pricing

Balanced Budget Act of 1997 Fee Schedule Changes

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

- Effective January 1, 1998, fee schedule amounts for blood glucose test or reagent strips (HCPCS A4253) will be reduced by 10 percent
- Effective January 1, 1998, fee schedule amounts for oxygen and oxygen equipment will be reduced by 25 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.
- Effective July 1, 1998, blood glucose test or reagent strips will be covered as inexpensive or routinely purchased DME.
- For 1999, the fee schedule amounts for oxygen and oxygen equipment will be reduced by an additional 5 percent.

Correction

Due to the development of code L1843, a review and correction has been made to code L1844. Fees will be published in the next quarterly newsletter.

Claim Processing

HCFA 1500 Form

The HCFA 1500 form has **not** been revised.

Only the instructions and printing specifications for the 1500 form have been updated. Part of these instructions deal with necessary changes a a result of the impending Year 2000. These millennium changes must be implemented as of October 1, 1998.

ESRD Update

The National Medicare Care Inc.-V Shalala litigation is still pending. Since this case is still pending, and because the time period for the filing of initial claims for End Stage Renal Disease services provided from August 10, 1993 through April 24,1995 would normally have expired on December 31, 1995, or December 31, 1996, the HealthCare Financing Administration is extending the time period for the filing of **these claims only** until December 31, 1997. This extension does **not** apply to claims for initial End Stage Renal Disease services provided after April 24, 1995.

Reminders

Refractive Lenses

When billing for refractive lenses and/or frames, keep in mind that when a supplier accepts assignment, they agree to accept the payment for services provided in the amount set by the Medicare Carrier as total amount for covered services; that is, the reasonable charge. An exception to this is in instances when the beneficiary chooses deluxe frames, in which case, the supplier may bill the beneficiary an additional charge for the deluxe feature. The patient should not be charged up front for the services provided, as payment will go directly to the supplier from Medicare. Also, remember that suppliers who choose to be participating suppliers voluntarily agree to accept assignment for all items and services furnished to Medicare beneficiaries, and that accepting assignment means accepting Medicare's approved amount as payment in full. Non-participating suppliers can accept assignment on a case-by-case basis. A revised Refractive Lenses Policy is included in the attached Supplier Manual revision.

Home Blood Glucose Monitors and Supplies

When billing for items such as blood testing strips and lancets that require a ZX modifier, remember that the ZX modifier is used to indicate that the patient is an insulin-treated diabetic, and there is a physician order including a statement to this effect. In some cases, patients who are put on insulin are later taken off insulin. Suppliers should be aware that in situations such as this, the patient's file must be updated and the ZX modifier should no longer be used as the requirement of being insulin-treated is no longer being met.

Electronic Data Interchange

The Electronic Data Interchange department has begun a new EDI analysis program. The objective of this program is to identify why claims are submitted via paper, when all DME Medicare claims can be transmitted electronically. Our goal is to assist submitters in raising their electronic percentage. Currently the EDI department is closely monitoring reports and tracking the electronic / paper percentage. In the first stage of this project, surveys were sent to randomly selected submitters to identify the most common reasons why claims are submitted via paper. An electronic claim can be processed and adjudicated 50% faster than a paper claim. The payment floor for processing of a clean EDI claim is 13 days minimum to 30 days compared to 27 days minimum to 30 days for a clean paper claim. These surveys are currently being reviewed and the findings are being addressed. If you were not chosen for this survey and submit any percentage of your claims via paper we would like to know what problems you encountered when billing electronically. Please feel free to contact the EDI department at (717) 735-9429 or write to us at:

EDI Department, Marketing Survey
United Healthcare
PO Box 6800
Wilkes-Barre, PA 18773-6800.

Important EDI Numbers

Bulletin Boards

Non-Participating Suppliers

717-735-9515

Participating Suppliers

800-842-5713

Remittance BBS

717-735-9451

TDD Provider Number

717-735-9639

EDI Help Desk

717-735-9429

Medicare Website

www.medicare-link.com

EDI Facts

The current EDI percentage is 77.5%. Our goal is to raise this percentage to 85% by December 31, 1997. The third quarter percentage was 78.8%. The average number of paper claims received in a day is 7590; the average number of EDI claims received in a day is 26183.

Important NSF 3.01 Information

All claims received on or after April 1, 1998 must be using the new NSF version 3.01. This version of the National Standard Format accommodates the updated CMNs for Wheelchairs, Lymphedema Pumps, Osteogenesis Stimulators, and Oxygen.

Currently vendors are testing with version 3.01. If you are using a vendors software, please contact them to get the upgrade prior to March 31, 1998.

Accelerate Software users please fill out the order form to request the 3.01 release.

Change of Address

If you change your address with the National Supplier Clearinghouse and you submit your claims electronically, you must also notify the Region A DMERC EDI Department.

Transfer Claims

If you are submitting claims to the Region A DMERC, that need to be transferred to another Region, or if you are transmitting claims directly to Region B, C or D you will need to contact the appropriate region to be set up in their system. Listed below are the phone numbers for their EDI Departments.

Region B 800-952-2068
Region C 803-788-0222
Region D 208-333-2141

BBS Mail Bulletins

On January 13, 1997 procedures were set in place to only keep Mail Bulletins for 6 months from the date of issue on the BBS. After receiving a new message on the BBS, we suggest that you print a copy for your records. This new procedure will significantly reduce the logon time required to reach the main menu.

New Acknowledgment Reports

The EDI Unit has been returning acknowledgment reports in a new layout since January of 1996. The acknowledgment reports are now ending with an AKS extension. Genacks2 is Region A DMERC's free print program. If you are using Region A DMERC's Accelerate software Version 02.00 you should have installed this program from your disks. Genacks2 is also located on the Bulletin Board for you to download if you are not using our program. If you are using a vendor's software you should contact your vendor for information on how to download and print your acknowledgment reports. If you are a programmer and need a copy of the file layout for the new acknowledgments please call the EDI unit.

Electronic Remittance Notices (ERN)

The Region A DMERC is currently returning ERN files in version 1.04 or 2.00. If you are currently using a vendor software and would like to start receiving ERN's contact the EDI department.

Electronic Remittance Notices (ERN Version 2.01)

Beginning March 5, 1998 Region A DMERC will begin supporting Version 2.01 of the ERN National Standard Format. If your vendor requires a copy please contact Team EDI.

Options to Check Claim Status

Two options the Region A DMERC has available to electronic submitters to check claims status are:

On-Line Claim Status

The on-line claim status is available to any provider that submits claims electronically to the Medicare Region A DMERC office. This system will allow your office to verify assigned claims status at your convenience during business hours (8:00AM to 4:15PM). This capability is accessed through the IBM Information Network (IIN also referred to as ADVANTIS) via an asynchronous connection.

Weekly Status Report

Suppliers are able to access the weekly status report through the toll number (717-735-9451) on the Remittance BBS. This report shows all assigned pending claims that are processing in our system. The weekly status report is updated every weekend and is available to download every Monday.

To be setup for either one or both of these options contact the EDI Help Desk.

Zipped EDI Files

The DMERC EDI Unit can accept production files which are submitted in a zipped format. This allows for multiple files to be sent at once and cuts down on transmission time. If you are interested in this option you **must** contact the EDI Unit to be set up before transmitting zipped files. Once you are set up for sending zipped files, you can **only** send zipped files. There are certain guidelines that you must follow when sending zipped files to our office. Please call the EDI Unit for an explanation of these guidelines.

NOTE: Accelerate users would need to purchase a software compression program to zip files.

Internet Account

The Region A DMERC has an Internet E-Mail Account available for correspondence. The E-Mail address :

dmerca@ix.netcom.com

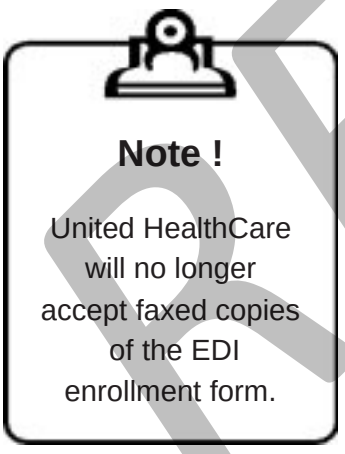
Please feel free to E-Mail us at your convenience. We cannot respond to E-Mail questions without your supplier number. Please remember to include your supplier number/NSC# on all E-Mail correspondence.

The BBS Supplier Questionnaire System

An electronic inquiry system has been implemented on the EDI Bulletin Board System. This system will allow suppliers to direct questions and inquiries to various departments of the DMERC and receive a response in a timely manner. Currently there are question forms for MSP/Accounting and the Professional Relations Departments. This list will be expanding to include other departments at our office. The questionnaires can be found under menu pick <1> Ask the DMERC. If you have a question for a department that is not currently listed you may use the BBS General Mail Messages to forward your question. The alternative message system may be found under menu pick <M> option <A> Ask the E-Team.

Messages left on the Bulletin Board will be responded to within 48 hours (2 working days). Please feel free to use the questionnaires as an alternative form of correspondence with the DMERC, and use them as often as needed.

Any questions you may have regarding " Ask the DMERC " option may be directed to us via the BBS mail system or by calling the EDI Department.



National Telecommunications Standards

The Region A DMERC does not limit the number of claims or the number of providers in a single transmission. We offer data compression, either through the use of the v.34 28.8kb modem or through PKZIP version 2.04g whichever the biller requests.

Effective October 1, 1996, for Asynchronous communications, we will support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP) via dial up, compliant with Internet Request for Comment (RFC) number 1122 and 1123, using Serial Line Internet Protocol (SLIP) or Point-to-Point Protocol (PPP) via File Transfer Protocol (FTP). We will continue to support all current Protocols as well. Questions regarding this subject may be directed to the EDI Department.

Testing with the Region A DMERC

If you are using a Vendor's software you must pass testing with us. A test submission must contain 20-30 claims. The test results will be provided to submitters, providers and/or vendors (as appropriate) within 3 working days. You must achieve a 95% data accuracy to pass testing, enter into, and stay in production. Testing information will be sent to you upon request.

Test Results

Beginning May 1, 1997 test results are no longer being faxed. They are part of the testing process and can be downloaded from our BBS, 48 hours after the test transmission. If you have any questions regarding the test acknowledgment feel free to call our office at 717-735-9429.

Once you have passed testing with an accuracy rate of 95% or better you will receive a call from the EDI Department informing you of a successful test; at this time Team EDI will check to make sure we have all the correct documentation on file.

Functional Acknowledgment Standard Format

On October 1, 1996, we began to provide the Functional Standard Format Acknowledgment to all requesting providers in response to flat file submissions. The Functional Standard Format Acknowledgment is an alternate file layout specification developed by HCFA. All four DMERCS will support this file format. If you are interested in receiving the file layout for this report please contact the EDI Support Team. We will continue to return the acknowledgment reports that we are currently supporting.

Disk Submitters

Effective October 1, 1998, provided that it is cost efficient we will continue to accept claims submitted via disk. However after this date the paper claims payment floor will be applied to claims received in this manner.

Billing Services and Clearinghouses

Claims related data may not be disclosed to anyone other than the provider, supplier or beneficiary for whom the claims was filed. Such information is included in claims, remittance advice, eligibility information, on-line claim status, and any other transactions where medical information applicable to an individual is processed or transported.

Secondary Insurance

If you are including Secondary Insurance information on the claims that you transmit to us all required information must be completed.

If your Secondary Insurance type is MG or OT an OCNA(Other Carriers Name and Address) Number is required. If you do not fill in an OCNA Number your claims will reject on the Front End Edits.

If the Secondary Insurance Company does not have an OCNA Number this information does not need to be sent to us. You should answer no for Secondary Insurance in this case. A complete list of OCNA Numbers is contained in your Supplier Manual.

Medicare Secondary Payer (MSP)

If submitting electronically when there is no insurance primary to Medicare **DO NOT** send a DA1 or DA2 record. These records are only required on Medicare Secondary Payer (MSP) claims. Using these records incorrectly may cause front end rejects or slow down the adjudication process of your claims.

If you have any questions on the correct usage of these fields and you are using Region A DMERC's Accelerate software please contact the EDI Unit. If you are using a vendor's software please contact your vendor with any questions.

Dialing our Bulletin Board more than 10 times a day

If you are an electronic submitter that dials the Region A Bulletin Board System 10 times or more a day to send production claims please contact us. We need to change your account information on the Bulletin Board so you don't encounter any problems with your files being overwritten. If you need to have access 10 or more times a day please contact the EDI unit.

Common Errors Made With Electronic Billing

All of the electronic claims that are received by our office run through a series of front end edits. These edits are based on the fields in the National Standard Format. The only claim format that we accept is the NSF(National Standard Format). Whether you are using our free software program or a vendor's software the claims being transmitted to us are NSF. The following are the most common errors that we see suppliers making on their electronic claims:

1. **Addresses being constructed incorrectly** Any address that is used on an electronic claim must follow these guidelines:

Street Address

- May not contain a space in the first position
- Must contain at least one embedded space
- May contain

  A-Z
  0-9
  forward slash (/)
  period (.)
  comma (,)
  number sign (#)
  ampersand (&)
  parentheses '()'
  percent sign (%) - for: "in care of"
  blank ( )

  No other special characters are allowed.

Address 2 is always an optional field but if it is used it must be filled out in accordance with the above guidelines.

City

- First position must not be blank
- May Contain:

  A-Z
  period (.)
  comma (,)
  ampersand (&)
  blank ( )

  No other special characters are allowed.

2. **Replacement Item and Warranty Information(GU0 6.0 & 9.0)** This information is required when billing electronically.

3. **Service Dates (FA0 5.0 & 6.0)** On capped rental items the service from and to dates should be the same and the number of services should be one.

4. **Units of Service (FA0 18.0)** For the Region A DMERC this must be a whole number. If you are provided with a fractional unit of service round up to the next whole number.

5. **Exercise Routine on O2 CMN (GX1 6.0)** If the patient has a portable oxygen system this field is required and must be filled in.

6. **Patient Height (GU0 16.0)** This is required on the Parenteral and Enteral Nutrition CMN(10.02).

7. **Patient Weight (GU0 17.0)** This is required on the Parenteral and Enteral Nutrition CMN(10.02) and the Wheelchair CMN(02.02).

8. **Individual Names**

   Last Name and First Name

   - First position must be A-Z
   - May Contain:

     A-Z
     hyphen (-)
     blank ( )

   - No other special characters are allowed
   - Last Name must be at least two (2) positions in length
   - First Name must be at least one (1) position in length

   Middle Initial

   - Must contain A-Z or blank

   Company Names This field may be blank but if it is filled in it must follow these guidelines:

   - First position must be A-Z
   - May Contain:

     A-Z
     period (.)
     comma (,)
     hyphen (-)
     ampersand (&)
     blank ( )
     0-9

   - No other special characters are allowed
   - Must be at least two (2) positions in length

Biller Code Rejects

Region A DMERC only accepts the first six digits (biller code) of your NSC number in fields BA0-02, BA0-09 and YA0-02. All ten digits of your NSC number are required in field FA0-23. Files will be rejected through a secondary edit if any of these fields are incorrect. The EDI Department must be notified if you will be billing for more than one NSC number. Failure to notify us will also cause your claims to be rejected by the same secondary edits. Questions regarding biller code rejects can be directed to the EDI Department.

Interested in a Cost Effective and Accurate Method of Submitting DMEPOS Claims?

Electronic billing can supply the solution. Region A offers a **low cost** software program called "Accelerate" which uses a claim entry screen that resembles the HCFA -1500 form. The EDI Team will assist with software installation and provide the support needed to run this program.

Accelerate Software

Effective October 1, 1997 the Region A DMERC began charging for the cost of materials and shipping for **each** Accelerate software package. The cost for each package is $15.00. The new version of Accelerate became available mid October and incorporates version 3.01 of the National Standard Format and includes the latest CMN revisions. As an option, you may continue to submit the current CMN's along with the current NSF version 2.00 until the manditory cut off date of March 31, 1998.

- If you have paid $15.00 for the software and do not receive it by mid December, please contact the EDI Unit at (717) 735-9429.
- If you are interested in the current version please contact the EDI unit at (717) 735-9429.
- If you are interested in the updated version please complete the form below and return it with a check for $15.00 made payable to United Healthcare.

The Region A DMERC will not issue the updated version of Accelerate without payment. Only one software package will be mailed to each submitter, so please order the correct disk size. Questions regarding this or the software may be directed to the EDI help desk at (717) 735-9429.

Accelerate Software Order Form

Company Name:_____

Address: _____

Contact Name:_____

NSC Number: _____

Submitter Number:_____

DISKETTE SIZE OF DRIVE A: 3.5"_____ OR 5.25" _____

AMOUNT ENCLOSED $ _____

Mail to: **United Healthcare**
Region A DMERC
PO Box 6800
Wilkes-Barre, PA 18773-6800
ATTN: Accelerate / EDI Dept.

DMERC Regions A, B, C and D
Certified and Selected Certified Vendor Lists

In order to assist you in obtaining a software vendor to meet the specific needs of your company, you will find a copy of the Certified Vendor List and a copy of the Select Certified Vendor Lists attached. *This document is intended to be used as an informational tool and should not be construed as the DMERC's personal recommendation.*

Program specifics vary with each Software Vendor and we suggest you analyze your business needs to determine if the program being offered will meet your billing needs as your business grows. Having a list of the items you are looking for in a billing program will help you decide which software program best fits the needs of your company as you begin calling the Software Vendors on this list.

The following are the criteria that define whether the software vendor is Certified or Select Certified:

- **We may classify a vendor as "Certified" provided that they have:**
  - Passed **any** DMERC's approved vendor testing criteria.
  - Routinely reported to us that they have installed a new billing system at a client site.

- **We may classify a vendor as "Select Certified" provided that they:**
  - Meet the minimum criteria for a "Certified" vendor.
  - Do not charge exclusively for their electronic claims feature.
  - Have **at least three** providers submitting DME claims electronically.
  - Add a minimum of one new DME electronic claims submitter every six months.
  - Support Claim Status Inquiry.
  - Support Electronic Remittance.

Please remember that the DMERCs make every effort to verify that the information contained on these lists is accurate but all information is subject to change. It is your responsibility to verify the accuracy of any information given by the Software Vendor.

Certified Vendor List

Company Name	Phone	Contact	Address	City	ST	Zip
Applied Software Technology	(800) 678-1111	Debra Atlas	591 Hamilton Avenue #201	Campbell	CA	95008
Bluff Creek Systems		Charles Judge	2824 Terrel Road	Greenville	TX	75401
California Medical Systems	(714) 789-0433	Mike Kazemi	27 Mauchley #209	Irvine	CA	92718
CDL Healthcare Systems	(305) 822-5566	Theresa Fusco	8181 NW 154th St, Ste 220	Miami Lakes	FL	33016
Companion Technologies	(803) 788-0222	DanaTucker	I-20 East @ Alpine Rd	Columbia	SC	29219
Complex Corporation	(718) 343-1001	Andy Cohen	21 Lodge Road	Great Neck	NY	11022
Computer Applications Unlimited	(717) 541-0651	Scott D Straining	6360 Flank Drive, Ste 100	Harrisburg	PA	17112
Computers Unlimited	(406) 255-9500	Heidi Thometz	2407 Montana Ave	Billings	MT	59101
Computers Unlimited - West Coast	(503) 692-7256	Mark Whitaker	PO Box 10719540 SW Tualatin-Sherwood Rd	Tualiton	OR	97062
Cortex	(714) 671-1184	Ani Modiano Haim Modiano	737 W Oakrest Avenue	Brea	CA	92821
Curtis Software	(330) 376-7665	David Kosakowski	520 South Main Street, Ste 2521	Akron	OH	44311
Cyber Software, Inc.	(616) 954-1900	Deb Mowry	1884 Breton Road SE, Suite 260	Grand Rapids	MI	49506
DataHouse, Inc	(205) 972-9292	Sam Willingham	One Perimeter Park South, Ste 100 S	Birmingham	AL	35243

Company Name	Phone	Contact	Address	City	ST	Zip
Dezine Healthcare Solutions, Inc	(800) 264-4674	Sales Team	1 Sugar Creek Center Blvd, Suite 850	Sugarland	TX	77478
Dezine Healthcare Solutions, Inc	(800) 264-4674	SALES	758 Hwy 18, Ste 110	East Brunswick	NJ	08816
Dynamic Energy Systems	(800) 326-0314	Phil Cody	700 E Park Blvd, Ste. 104	Plano	TX	75074
EXT Software Services, Inc.	(704) 889-2860	A J Barretta	600 Towne Centre Blvd, Ste. 100	Pineville	NC	28134
Fastrack Healthcare Systems, Inc.	(800) 520-2325	Fred Lang	255 Executive Drive	Plainview	NY	11803
FSAR	(215) 635-0669	Barbara O Brien	7914 Heather Rd	Elkins Park	PA	19027
Futura International	(813) 791-3332	Terry Long	22051 US Hwy 19 N	Clearwater	FL	34625
Hann's On Software	(707) 823-6089	John Crosby	321 S Main St #44	Sebastopol	CA	95409
Healthcare Computer Corporation	(800) 777-4309	Tracy Ward	2601 Scott Avenue, Ste 600	Fort Worth	TX	76103
Hi Tech Software	(207) 474-7122	Michael Salisbury	1 Silver Street	Skowhegan	ME	04976
Info Services, Inc.	(601) 898-7858	Tommy Ladner	145 Executive Drive, Suite 2	Madison	MS	39110
InfoQuest Systems, Inc	(800) 414-9899	Nitin Mehta	256 Chapman Road	Newark	DE	19702
Integrated Software Solutions, Corp.	(305) 436-9090	Thedy Brezault	7220 NW 36th Street, Suite 645	Miami	FL	33166
Keystone Medical Systems	(800) 800-0764	Joe Maurer	3 Lemoyne Drive, Ste. 100	Lemoyne	PA	17043
Kiyo Systems, Inc.	(714) 556-5667	Scott Momii	PO Box 3239	Newport Beach	CA	92659
Management By Information	(501) 661-0386	Sherry Walker	2224 Cottondale Ln, Suite 102	Little Rock	AR	72202
Med 2000	(310) 316-9110	Frank Smith	PO Box 489	Redondo Beach	CA	90277
Med 2000 Georgia	(770) 992-3352	Bob Goligoski	3130 Birchton Street	Alpha Retta	GA	30202
Med 2000 Louisiana	(504) 767-0725	Don Cannon	3017 Valcour Aime Avenue	Baton Rouge	LA	70820
Med 2000 Northwest	(503) 873-4320	Linda Freeland	PO Box 13811	Salem	OR	97309
MedFlex Corporation	(219) 583-6106	Charles Mason	PO Box 880	Monticello	IN	47960
Medic Computer Systems	(919) 848-5791	Tim Clark	8601 Six Forks Road, Ste. 300	Raleigh	NC	27615
Medical Office Software, Inc.	(954) 476-8177	Doug Wolverton	2280 SW 70 Avenue, Unit 9	Davie	FL	33317
Medical Office Software, Inc.	(303) 271-0944	Mark Workman	17764 W 53 Dr Prosthetic and Orthotic Division	Golden	CO	80403
Medicare Data Systems, Inc.	(908) 852-4500	Barry Gruber	425 Sand Shore Road	Hackettstown	NJ	07840

Company Name	Phone	Contact	Address	City	ST	Zip
Medix Systems Consultants, Inc.	(708) 331-1271	Angela U Nwatah	17050 S Park Avenue, Ste. C - D	South Holland	IL	60473
MedWare	(904) 427-0558	Jeannette Carter	1055 N Dixie Freeway Suite 2	New Smyrna Beach	FL	32168
Megas Corporation	(904) 668-3922	Jan Powell	1419 Market Street	Tallahassee	FL	32312
Megawest Systems, Inc.	(800) 999-0788	Jolynn Potter	345 Bearcat Dr	Salt Lake City	UT	84115
MG Research	(818) 552-2593	Greg or Nara	720 E Orange Grove Ave, Ste, 15	Glendale	CA	91205
Micro Edge		Herb	76 Progress Drive	Stamford	CT	06902
MTA Systems, Inc.	(315) 468-0977	Colleen Derosa	4312 W Genesee Street	Syracuse	NY	13219
Noble House	(561) 392-6700	Lisa Stone	190 W Glades Rd, Ste D	Boca Raton	FL	33432
P C Solutions	(800) 445-5473	SALES	PO Box 457	Brooklyn	CT	06234
Pacware Software Development	(916) 348-8514	Cyndi Maynard	8229 Pinefield Drive	Antelope	CA	95843
Paranet Software	(910) 774-7095	Carl Jones	1959 N Peace Haven Rd #273	Winston-Salem	NC	27106
Practical Computer Solutions, Inc.	(618) 345-7232	John Brennan	537 Vandalia St PO Box 777	Collinsville	IL	62234
Practiputing Inc	(206) 848-4443	Melody Plett	16923 Meridian E, Ste APO Box 73188	Puyallup	WA	98373
Pro Business Systems, Inc	(904) 479-9035	Jake Odom	6266 N W St	Pensacola	FL	32505
QS/1 Data Systems	(800) 845-7558	Buddy Burk	PO Box 6052	Spartanburg	SC	29304
Reimbursement Services, Inc.	(864) 458-8884	Terry Frum	PO Box 27145	Greenville	SC	29616
Rockhopper Systems, Inc.	(504) 767-2533	Bill Bethea	5745 Essen Lane Ste 210	Baton Rouge	LA	70810
Sierra Healthcare	(310) 468-0040	Sam Ohm	17215 Studebaker Rd, #120	Cerritos	CA	90703
Software Solutions		Rudy	2604 Elmwood Ave #242	Rochester	NY	14623
Solutions Plus, Inc.	(516) 378-0710	Stuart Sipo	2049 Correll Place	Merrick	NY	11566
Systems Management, Inc.	(219) 271-3200	Ann Huffman	53702 Generations Drive	South Bend	IN	46635
Team DME! / Spectrum Software Inc.	(800) 832-6289	Duane Ridenour	5042 Linbar Dr, Ste 103	Nashville	TN	37211
TechPro Systems, Inc.	(800) 437-0773	Laurie Tanczer	255 Bear Hill Road	Waltham	MA	02154
The Medical Connection Service Bureau	(516) 679-2373	Les Young	7 Dell Lane	Wantagh	NY	11793
Tropical Software Service	(813) 321-1797	Eric Christiansen	6860 Gulfport Blvd S, Ste. 270	St Petersburg	FL	33707
Wismer Martin	(800) 231-7477	Rick Williams	12828 N Newport Highway	Mead	WA	99021

Select Certified Vendor List

Company Name	Phone	Contact	Address	City	ST	Zip
Complex Corporation	(718) 343-1001	Andy Cohen	21 Lodge Road	Great Neck	NY	11022
Computers Unlimited	(406) 255-9500	Heidi Thometz	2407 Montana Ave	Billings	MT	59101
Curtis Software	(330) 376-7665	David Kosakowski	520 South Main Street, Ste 2521	Akron	OH	44311
Cyber Software, Inc.	(616) 954-1900	Deb Mowry	1884 Breton Road SE, Suite 260	Grand Rapids	MI	49506
Dezine Healthcare Solutions, Inc	(800) 264-4674	Sales Team	1 Sugar Creek Center Blvd, Suite 850	Sugarland	TX	77478
Dezine Healthcare Solutions, Inc	(800) 264-4674	SALES	758 Hwy 18, Ste 110	East Brunswick	NJ	08816
Dynamic Energy Systems	(800) 326-0314	Phil Cody	700 E Park Blvd, Ste. 104	Plano	TX	75074
Fastrack Healthcare Systems, Inc.	(800) 520-2325	Fred Lang	255 Executive Drive	Plainview	NY	11803
Integrated Software Solutions, Corp.	(305) 436-9090	Thedy Brezault	7220 NW 36th Street, Suite 645	Miami	FL	33166
Management By Information	(501) 661-0386	Sherry Walker	2224 Cottondale Ln, Suite 102	Little Rock	AR	72202
Med 2000 Northwest	(503) 873-4320	Linda Freeland	PO Box 13811	Salem	OR	97309
Medical Office Software, Inc.	(954) 476-8177	Doug Wolverton	2280 SW 70 Avenue, Unit 9	Davie	FL	33317
MG Research	(818) 552-2593	Greg or Nara	720 E Orange Grove Ave, Ste, 15	Glendale	CA	91205
Noble House	(561) 392-6700	Lisa Stone	190 W Glades Rd, Ste D	Boca Raton	FL	33432
P C Solutions	(800) 445-5473	SALES	PO Box 457	Brooklyn	CT	06234
Pacware Software Development	(916) 348-8514	Cyndi Maynard	8229 Pinefield Drive	Antelope	CA	95843
Paranet Software	(910) 774-7095	Carl Jones	1959 N Peace Haven Rd #273	Winston-Salem	NC	27106
Team DME! / Spectrum Software Inc.	(800) 832-6289	Duane Ridenour	5042 Linbar Dr, Ste 103	Nashville	TN	37211
Tropical Software Service	(813) 321-1797	Eric Christiansen	6860 Gulfport Blvd S, Ste. 270	St Petersburg	FL	33707

Outreach

Educational Workshops in Retrospect

The Region A DMERC recently completed its fall round of seminars. Workshop topics included; Parenteral and Enteral Nutrition, Mobility, Documentation / CMN and Electronic Data Interchange. Eleven workshops were held throughout Region A's ten state territory.

Attendees who completed seminar evaluation forms rated these seminars highly favorably. The experience was perceived as above average by 68%, while 31% indicated an average assessment. Only 1% reported unsatisfactory results. Here are a few examples of the many positive comments we received.

- *"Excellent seminar!"*
- *"Very interesting and informative workshop. Much improved over workshops I've attended in the past."*
- *"Made...subject much more interesting. Didn't just read from the booklet. Made information understandable. Great presentation!"*
- *"This session was extremely well presented and very informative."*

(Fall 1997 Continuing Education Workshop, Scranton, PA, Paul Komishock, Ombudsman)

Seminar Registration Fee

The seminar registration fee is based on the following expenses:

- Number of estimated attendees
- Seminar room rental, lunch, coffee,
- Seminar materials,
- Travel expenses associated with conducting a seminar, etc.

Conducting the seminars/workshops does not yield a profit to United HealthCare. Our goal is only to collect enough revenue to offset the non-salary expenses for the seminars. For the past several sessions we have been very close in offsetting the expenses.

Congressional Beneficiary Outreach

The Region A DMERC has recently completed a series of educational sessions in cooperation with five congressional offices. The states of Pennsylvania, New Jersey, Rhode Island, Maine and New York were represented. These sessions were completed with one congressional office in each of the five states.

The purpose of these sessions was to educate beneficiaries on Medicare and DMERC issues, to increase awareness of the United HealthCare name as the Medicare carrier for DMEPOS (Durable Medical Equipment Prosthetics Orthotics and Supplies) and to give the congressional office the ability to increase their responsiveness to their constituents. The end result is an informed beneficiary community.

(Left to Right) Thomas O'Connor, Ombudsman and Beneficiary Outreach Coordinator, Senator Jack Reed, and David Fiorini, Congressional Liaison

In cooperation with these congressional offices, the DMERC developed a Medicare beneficiary outreach program which included information on Durable Medical Equipment, Participation, Assignment, and Program Integrity. Location, advertising, and overall format was arranged by the congressional office staff. The session held in Pennsylvania for Congressman Tim Holden included representatives from the Medicare Part A intermediary and Part B carrier as well as a Social Security Representative. The session in New York for Congressman Jim Walsh included representatives from the Part A Intermediary and local Part B carrier. The DMERC was the sole presentor at the events organized by Senator Olympia Snowe of Maine, Senator Jack Reed of Rhode Island, and Congressman Christopher Smith of New Jersey.

The representatives of the DMERC who presented information included Ombudsmen, Michele Healey, Doris Spencer and Thomas O'Connor as well as the DMERC Congressional Liaison, David Fiorini.

The overall results and feedback from all involved has been very positive in increasing Medicare program awareness. In total we have reached approximately 500 beneficiaries at these events in 7 locations.

As we progress with our beneficiary outreach programs we will continue to form events such as this to provide information relative to the Medicare program.

Ombudsmen and Medical Director Attend New England Medical Equipment Dealers Association's Annual Meeting

Doris Spencer, Orthotic and Prosthetic Ombudsman, Michele Healey, Respiratory Ombudsman, and Dr. Paul Hughes, Medical Director, attended the New England Medical Equipment Dealers Association (NEMED) annual meeting that was held May 28-30, 1997, at the historical Hotel Viking in Newport, Rhode Island.

The Ombudsmen had an exhibitor's booth on May 28-29, where various DMERC information was displayed. The Ombudsmen answered numerous questions from suppliers who visited the booth.

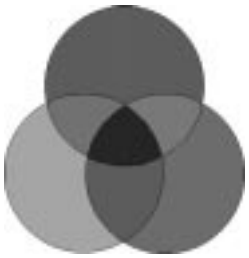
On Thursday, May 29, 1997, Dr. Paul Hughes, Region A Medical Director, discussed Medical Policy development and Individual Consideration for durable medical equipment, prosthetics, orthotics and supply claims. Doris Spencer's and Michele Healey's presentation on Product / Process Focus Group (P / PFG) implementation and various DMERC updates followed.

The NEMED Association was receptive to the DMERC presentation and our presence at the exhibit booth. The Region A DMERC is planning to attend the convention again next year.

(Left to Right) Michele Healey, Respiratory Ombudsman and Doris Spencer, Orthotic and Prosthetic Ombudsman

Hearings/Appeals

Appeals Analysis Program



United HealthCare has implemented an Appeals Analysis Program (AAP) for all DMEPOS claims. Each quarter, the top 15 HCPCS codes that are initially denied but paid upon review will be identified. The reason for the initial denial can then be determined as one of three causes: a processing error, a system programming error, or a supplier submission error.

Once identified, the appropriate action will be taken to resolve the problem, thus eliminating unnecessary reviews. Processing errors or system problems will be swiftly addressed by the Region A DMERC. In situations where claims were submitted incorrectly, the Region A DMERC will identify the problem and provide the individually affected suppliers with the proper steps to avoid unnecessary reviews in the future.

By instituting the use of the AAP, the Region A DMERC can significantly decrease the number of claims that unnecessarily go through the review process. Suppliers will receive appropriate payment more promptly and eliminate wasted time and effort associated with the review process.

If you are identified as a supplier that falls under AAP consideration, you will receive a letter from the Professional Relations Department identifying the particular HCPCS code and the appropriate action to take. Look for the  logo identifying the letter as part of the **Appeals Analysis Program.**

The Appeals Process..... Reconsiderations, Hearings and More

The appeals process gives the beneficiary / provider / supplier the opportunity to exercise their rights to due process if they do not agree with the initial determination given on their claim. The process is as follows:

- Review
- Hearing
- Administrative Law Judge
- The Appeals Council of the Office of Hearings and Appeals
- United States District Court

A brief description of each segment of the process is listed below.

Review

We commonly refer to the review as a recon or reconsideration. This is the first level of appeal available to concerned parties. The Recon Unit has experienced personnel who perform an independent review of the claim(s) in question. If there is any additional information available regarding the claim, it should be submitted and will be evaluated in accordance with Medicare law regulating the process. The time limit for filing a request for a review is **six months** from the date of the EOMB. You must ask, in writing, for the review, or, if you are an EMC submitter by fax. When requesting a review, please use language stating as precisely as possible, what you would like done. For instance: “Please review this claim” or “Please reconsider this claim.” This will assure you, and assist us, in making sure the claim is assigned to the proper unit. Also, inclusion of the following will help us to process your request quicker:

- Date of the service,
- Issue in question,
- Control number of the claim, and
- A copy of the Explanation of Medicare Benefits (EOMB)

If our decision results in a partial reversal or affirmation of our original decision, we will issue a letter to the requester addressing the concerns raised in the review request. If the decision is a full reversal, you will receive additional payment and a new EOMB.

Hearings

If you are dissatisfied with your review (or recon) decision, the next step in the appeals process is to request a hearing. In any hearings case, an impartial hearing officer is assigned the case and he/she will hear testimony regarding the claim. The request for a hearing must be made within **six months from the date of the review decision notification.** To be eligible for a hearing, the amount in controversy must be at least $100. If the claim in question does not reach the $100 threshold:

- You may combine other claims that have already been through the review process for a dollar value that will meet the $100 threshold;
- If you do this, all claims must belong to the same beneficiary or assignee, and
- All claims must be within the six month time limit after the initial review determination.

If a beneficiary is requesting the hearing, claims from more than one physician/supplier may be combined. If the provider is requesting the hearing, the provider may combine claims involving more than one beneficiary.

Note: The amount in controversy is the difference between the amount billed and the amount paid minus any deductible and/or coinsurances charged.

Example:

$1000 is billed. $640 is paid based on an $800 reasonable charge.

The amount in controversy is ($1000 - $640) - $160 (20% of $800 allowed) = $200.

There are three types of hearings:

- On the Record - a hearing officer renders a decision based on the facts in the file. New information substantiating the claim may be submitted.
- Telephone - a hearing officer holds the hearing with the concerned party via telephone.
- In Person - a date is set for the hearing officer to meet with the claimant or assignee to discuss the facts about the case.

The hearing must be requested in much the same way as the review. A written request stating exactly what you are requesting, will assist both you and us in expediting the process and assuring accurate assignment of your material.

A copy of the decision will subsequently be mailed to each of the involved parties at his/her last known address.

Administrative Law Judge (ALJ)

The hearing officer's decision is final and binding unless the amount in controversy is at least $500. An ALJ hearing may be requested within **60 days** of the date of receipt of the hearing officer's decision. You must submit your written request to the hearing officer or carrier who rendered your decision. This request, with its accompanying material, will be sent to the ALJ, and a hearing will be scheduled. Please be sure to denote whether or not you wish to attend your hearing.

Office of Hearings and Appeals

If you are dissatisfied with the ALJ's decision, you may request a review by the appeals Council of the Office Of Hearings and Appeals of the Social Security Administration. The written request must specify the issues and findings of fact and conclusion of law made by the ALJ with which you disagree, as well as your basis for contending that the findings and conclusions are incorrect. You will be afforded rights similar to those aforementioned in the process.

United States District Court

If, at this point, you remain dissatisfied, you have the right to a judicial review in United States District Court. The amount in controversy must be at least $1000.

A "reopening" (a reevaluation of the claim determination) is not an **Appeal Right.** It is a **discretionary action** in response to the identification of an error, fraud, or the submittal of new and material information not available at the time of the last adjudication. There is no time limit on reopenings.

Closing

If there exits a pervasive problem and a meeting is required to rectify the problem, we will gladly schedule one. Educating you on our process benefits all parties involved. It helps keep your office work flowing, your reimbursement timely, and headaches to a minimum. It also helps us keep work directed to the proper area in our office, expediting turnaround.

This brief explanation of the appeals process and its components is , by no means, exhaustive by way of content. It should serve to better educate you on the process and, perhaps, give you an overview while answering any questions you might have.

The preceding information can be found in the 12000 section of the Medicare Carriers Manual (MCM).

Fair Hearing Reminders

- A review determination is a prerequisite for a hearing, however, if the initial claim is not acted upon with reasonable promptness, a hearing may be requested.
- Overpayments of $100 or more may be appealed through the hearing process. Overpayments of less than $100 may only be appealed through the reconsideration/review process.
- The request for a hearing must be received within 6 months of the date of the review/overpayment determination.
- The amount in controversy must be $100 or more. This means that after subtracting the deductible and/or coinsurance, at least $100 must remain in question.
- The hearing request must be in writing and signed by the claimant or their representative.
- The request must clearly identify the claims involved and the reasons for the appeal.
- The type of hearing requested must be indicated.
- Claims may be combined to meet the $100 requirement if:
  - The claims belong to the same beneficiary or the same assignee.
  - All the claims have been through the review process, except when the initial claim has not been acted upon with reasonable promptness.
  - All claims which are combined are within the 6 month filing time limit.

- Never submit multiple requests for a hearing for the same claim.

- All hearing requests are acknowledged within 10 days of receipt. If you have not received an acknowledgment within 20 days, please contact the Hearings Unit. Do not automatically submit another request.

- The timeframe for completion of the hearing is 120 days from the date received as evidenced on the acknowledgment letter.

Hearing Request Checklist

Please Be Certain That:

- A review has been completed for each claim in the request.

- The request will be received by the DMERC within 6 months of the date of the review / overpayment determination on each claim.

- The amount in controversy totals $100 or more.

- A copy of the review / overpayment determination is included with the request.

- All pertinent documentation is submitted with the request. For example, CMN's, Physician's letter, Returned Equipment Information etc.

- A clear explanation stating the reason for the appeal is present with the request.

- The type of hearing requested has been indicated.

Supplier Notices

Professional Relations distributes Supplier Notices as a method of notifying the Supplier Community of important changes in Medical Policy, Electronic Billing, Pricing or DMERC related activities via the Bulletin Board System (BBS), automated Response Unit (ARU), and faxed to the State Supplier Associations within Region A.

July 25, 1997
Supplier Notice 97- 24

Billing Clarifications - Surgical Dressings

A significant number of claims with identical HCPCS codes and dates of service are being billed on two separate claim lines. Recently, we have seen this billing practice for a large number of surgical dressing claims.

When duplicate HCPCS codes and dates of service are billed on two separate claim lines, *one of the claim lines will be denied CO-18*.

* CO-18 - contractual obligations, duplicate claim / service

In order to prevent this denial, duplicate HCPCS codes and dates of service must be combined on one claim line. The following **example** illustrates the incorrect and correct way these claims should be billed:

Example:	Date(s) of Service	CPT/HCPCS	Modifier	$charges	Days or Units
Incorrect	2/28/97	A6406	X5	$80.00	400
	2/28/97	A6406	X5	$90.00	400
Correct	2/28/97	A6406	X5	$170.00	800

By billing under the correct example, you will not receive a CO-18 denial. However, Medicare guidelines and medical policy coverage criteria must be met to allow any payment of the claim.

We are also receiving a great number of surgical dressing claims that are being submitted with more than one "X" modifier on one claim line. These claims will be denied CO-B18.

* CO-B18 - Contractual obligations, claim/service denied because this procedure code/modifier was invalid on the date of service or claim submission.

Example:	Date(s) of Service	CPT/HCPCS	Modifier	$charges	Days or Units
Incorrect	2/28/97	K0402	X3X1	$50.00	200

Please refer to the surgical dressing policy for the correct usage of the "X" modifiers.

July 25, 1997
Supplier Notice 97- 25

Product/Process Focus Groups (P/PFG)

Ombudsmen/Professional Relations

As we continue to progress with the P/PFG (Product/Process Focus Group) initiative, this article offers more details on this project as it pertains to the Ombudsmen and the Professional Relations Department.

An introduction to P/PFG was published in the March 1997 DME Medicare News. This initiative was also discussed at our Spring '97 seminars throughout April and at all of the recent State Association conventions/meetings.

The objective of the P/PFG initiative is to improve our service to the supplier community and produce a more consistent processing product.

The first step in initiating this project was to form six work groups representing each of the designated policy categories. The groups include a representative from each department within DMERC Region A which currently meet on a bi-weekly basis. These groups address and work to resolve issues that exist within their designated category.

Effective August 1, 1997, Ombudsmen will be assigned to specialty categories. Each will be assigned a primary product category and a secondary product category. In certain circumstances, geographic territory assignments as they have been established up to this point, will still remain. These circumstances will be addressed later in this article.

As of **August 1st**, there will be only one designated phone number to reach the Ombudsmen. The phone number will be 717-735-9666. When you contact the Ombudsmen at this number, you will be instructed to select the policy category in relation to your inquiry. You will then reach the Ombudsman assigned to that category.

This is a new direction for the DMERC Region A and we realize there will be questions as we move along in this process. The following are questions and answers as anticipated by Professional Relations:

Q. Which Ombudsman is assigned to which category?

A. Please refer to the chart following this article for Ombudsmen assignments.

Q. How will Ombudsmen assignments to PPFG categories affect previously assigned State Association contacts?

A. The Ombudsmen will continue as currently assigned to State Associations. Please refer to the chart following this notice.

Q. What does assignment of Ombudsmen to primary & secondary categories mean?

A. Each Ombudsman will be assigned to a category as their "primary" category. This category will be the one they are primarily involved in. The secondary category will be the category in which the Ombudsman will serve as back-up / support if the primary Ombudsman for that category is unavailable.

Q. What if I have a general question/issue that is not category specific?

A. General questions should be directed to our Provider Customer Service Unit at 717-735-9445. If necessary, the representative will refer the call to the appropriate Ombudsman.

Q. What if my question/issue is not general or category specific, but is an educational issue or an issue requiring the assistance of an Ombudsman?

A. There will be a selection option available when you contact the Professional Relations department designated "General Education" for this situation.

Q. What if I have questions/issues involving multiple categories?

A. If your questions / issues are of an educational nature or need the assistance of an Ombudsman, you should contact the Ombudsman assigned to your area code. This Ombudsman will gather information / responses as necessary and will respond to you. If necessary, you may request to speak to each category assigned Ombudsman for possible further discussion / resolution.

Q. Will the provider services unit be divided by PPFG categories?

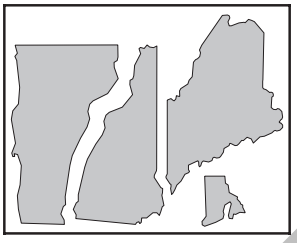
A. Not at this time, however, designated representatives from this unit for each PPFG are involved in the bi-weekly group meetings. Each is responsible to provide feedback to all customer service representatives as a result of the meetings.

Primary Role of Ombudsman

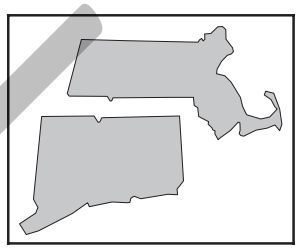
The primary role of the Ombudsman continues to be education and the information source between the DMERC and supplier community. The Provider Customer Service Unit and ARU system have both been strengthened to accommodate provider's needs. The supplier community has been directed to contact this unit as a first recourse for resolution to your questions / issues. The cooperation of the supplier community has enabled the Ombudsmen to concentrate on our true responsibilities, such as educational workshops and materials; attending trade shows & association meetings; conference calls; physician education; beneficiary education and resolution of issues affecting all suppliers. It has also enabled us to develop and implement the P / PFG's to improve our overall service to the supplier and beneficiary communities.

Professional Relations Ombudsmen

PR Representatives
Erin Groblewski, Kevin Quaglia



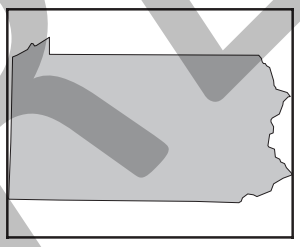
ME, NH, RI, VT
Area Codes:
207, 401, 603, 802
Michele Healey
State Association, NEMED



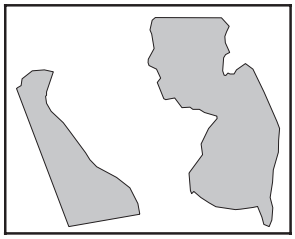
MA, CT
Area Codes:
203, 413, 508, 617, 860
Doris Spencer
State Association, NEMED

NY State
Area Codes:
315, 518, 607, 716, 914
Laura Viot
State Association, NYMEP

NY City and Long Island
Area Codes:
212, 516, 718, 917
Tom O'Connor
State Association, NYMEP



PA
Area Codes:
215, 412, 610, 717, 814
Amy Capece
State Association, PAMS



NJ, DE
Area Codes:
201, 302, 609, 908
Paul Komishock
State Association, JAMES

Product/Process Focus Groups
717-735-9666

Respiratory
Michele Healey - Ombudsman - Primary
Doris Spencer - Ombudsman - Secondary
Kevin Quaglia - PR Representative

- Oxygen Supplies / Equipment
- Nebulizers
- CPAP / BIPAP
- Suction Pumps
- Tracheostomy Supplies
- IPPB
- Ventilators

Mobility
Laura Viot - Ombudsman - Primary
Paul Komishock - Ombudsman - Secondary
Erin Groblewski - PR Representative

- Wheelchairs
- Walkers
- Canes / Crutches
- Repairs / DME
- Seat Lift Mechanisms
- Powered Operated Vehicle
- Seating Systems

Orthotics & Prosthetics
Doris Spencer - Ombudsman - Primary
Michele Healey - Ombudsman - Secondary
Kevin Quaglia - PR Representative

- Lower / Upper Limb Orthosis
- Spinal Orthosis
- Lower / Upper Limb Prosthesis
- Orthopedic Footwear
- Diabetic Shoes
- Orthotic / Prosthetic Repair
- Dynamic Splints

Supports
Thomas O'Connor - Ombudsman - Primary
Amy Capece - Ombudsman - Secondary
Erin Groblewski - PR Representative

- Hospital Beds / Accessories
- Trapeze Bars
- Commodes / Bed Pans / Urinals
- Support Surfaces
- Patient Lifts
- Traction

Nutrition/Pharmacy
Amy Capece - Ombudsman - Primary
Thomas O'Connor - Ombudsman - Secondary
Erin Groblewski - PR Representative

- Enteral Nutrition
- Parenteral Nutrition
- Immunosuppressive Drugs
- Infusion Pumps
- Dialysis Equipment / Supplies / EPO
- Oral Anti-Cancer
- Oral Antiemetic

Specialized DME
Paul Komishock - Ombudsman - Primary
Laura Viot - Ombudsman - Secondary
Kevin Quaglia - PR Representative

- Heat / Cold Application
- CPM & Neuromuscular Stimulator
- TENS & Osteogenic Bone Stimulator
- Vision - Lenses & Prosthesis
- Impotence Aid
- Voice Prosthesis
- Ostomy & Urologicals
- Surgical Dressings
- Breast Prosthesis
- Maxillofacial / Miscellaneous DME
- Lymphedema Pumps
- Investigational Devices
- Glucose Monitors

Reminder: The ***Secondary*** Ombudsman serves as backup / support to the ***Primary*** Ombudsman for the product category.

July 29, 1997
Supplier Notice 97- 26

Attention!! Accelerate Software Users

Effective October 1, 1997 the Region A DMERC will begin charging for the cost of materials and shipping for each software package mailed. The cost for the Accelerate software package will be $15.00. We are notifying you, the supplier community, in preparation of the new version of Accelerate that will be available this fall. The new version will incorporate version 3.01 of the National Standard Format (NSF) and include the latest Certificate of Medical Necessity (CMN) revisions. More information will be released as it becomes available.

Questions regarding the above information or the software may be directed to the Region A DMERC EDI help desk at 717-735-9429, Monday - Friday 8:00 a.m. - 4:00 p.m..

July 29, 1997
Supplier Notice 97- 27

New Oxygen CMN (DMERC 484.2)

The new certificate of medical necessity (CMN) for Oxygen (DMERC 484.2) that is included with the July newsletter is incorrect. In section A of the Oxygen CMN, the recertification box was omitted.

When using this CMN for a recertification, cross out the word revised, write recertification and place the date in the appropriate space. A revised Oxygen CMN will be published in the future.

If you have any questions on the above information, contact our Provider Services Unit at 717-735-9445, Monday - Friday, 8:00 a.m. to 4:00p.m..

August 1, 1997
Supplier Notice 97- 28

Acknowledgment Reports

As of October 1, 1997, with the implementation of version 3.01 of the National Standard Format (NSF), we will no longer be faxing acknowledgment reports to electronic submitters. If you are experiencing problems, please call our EDI help desk at 717-735-9429, Monday through Friday, 8:00 am - 4:00 pm.

There will be no exceptions.

August 25, 1997
Supplier Notice 97-29

Date of Service / Date of Delivery / Date of Discharge

The Region A DMERC has been working closely with HCFA (Health Care Finance Administration) to obtain clarification on the relationship of date of service, date of delivery and date of discharge.

As a result of our collective efforts, the following information has recently been issued for publication by HCFA to the DMERC:

"Medicare law limits Part B payment for DME to that which is used in the patient's home. Hospitals and nursing homes cannot be considered a patient's home for DME purposes. Generally, for all DMEPOS, the supplier's date of service (DOS) is the date of delivery to a beneficiary's home. For DMEPOS provided to a beneficiary immediately subsequent to a hospital inpatient stay and/or DME immediately following a nursing home stay, the DOS is the date of final discharge to the beneficiary's home. For mail order DMEPOS provided immediately subsequent to a hospital inpatient stay and/or DME immediately following a nursing home stay, the DOS is the latter of the actual shipping date or the date of discharge. Under no circumstances can the DOS be earlier than the date of delivery, or, in the case of mail order DMEPOS, the shipping date. "

The following are questions and answers as anticipated by the DMERC in reference to this notification:

1. Can I routinely provide DMEPOS prior to discharge?

   A. This should not be a routine practice. As stated above - "Generally, for all DMEPOS, the supplier's date of service is the date of delivery to the beneficiary's home." This clarification is to address those circumstances that may be an exception to this general rule, (e.g., beneficiary needs the DMEPOS immediately upon arrival at his/her home; the date of discharge changes or cannot be precisely determined before delivery.)

2. Can the DMERC provide a supplier with the date of discharge?

   A. Due to the Privacy Act, the DMERC cannot provide this information. This is the responsibility of the supplier to obtain from the beneficiary, hospital, nursing facility, etc.

This clarification does allow the supplier some flexibility as to when DMEPOS is delivered to a beneficiary who is to be discharged in the near future. However, the date of discharge should not be used unless the beneficiary requires and will use the DMEPOS as soon as they arrive home.

Delivery of DMEPOS to be used by the beneficiary prior to discharge in a facility considered to be an inappropriate place of service for the item provided, is not an acceptable practice as a result of this notification.

Submitting a claim for DME used in a facility other than a beneficiary's home, as defined in Chapter 12 of the Region A Supplier Manual, page 12-16, and billing an inappropriate place of service on the claim could constitute fraud.

September 12, 1997 Supplier Notice 97- 30

New Code for Methotrexate

Effective for dates of service on or after October 1,1997 the new NDC number for Methotrexate will be NDC# 00677-1610-01, manufactured by United Research Lab. This code must be used on claims submitted to the DMERC.

September 22, 1997 Supplier Notice 97-31

Supplier Alert

The Region A DMERC has recently developed a new method of notifying the Supplier community of important time sensitive information. This new method is called a "Supplier Alert". The Supplier Alert will not be published in the DME Medicare newsletter, however, they will be faxed to the State Supplier Associations and will be available on the Bulletin Board (BBS) for electronic submitters and the Automated Response Unit (ARU).

September 19, 1997 Supplier Notice 97-32

End Stage Renal Disease (ESRD) Coverage Update

Prior to enactment to the Balanced Budget Act (BBA) of 1997, Medicare benefits were secondary to benefits payable under a Group Health Plan (GHP) in the case of individuals entitled to benefits on the basis of ESRD during an 18-month coordination period. The coordination period begins with the first month the individual is eligible for Medicare, whether or not the individual is actually entitled or enrolled.

Under this provision, the GHP must be billed first for services provided to a Medicare ESRD beneficiary. If the GHP does not pay for covered services in full, Medicare may pay secondary benefits in accordance with current billing instructions. This provision applies to all Medicare covered items and services (not just treatment of ESRD) furnished to beneficiaries who are in the coordination period.

Section 4631 (b) of the BBA of 1997 permanently extends the coordination period to 30 months for any individual whose coordination period began on or after March 1, 1996. Therefore, individuals who have not completed an 18-month coordination period by July 31, 1997, will have a 30 month coordination period under the new law. This provision does not apply to individuals who would reach the 18-month point on or before July 31, 1997. These individuals would continue to have an 18-month coordination period.

October 13, 1997 Supplier Notice 97-33

Non-Licensed Pharmacy

A drug used as a supply with DME or a prosthetic device (e.g., nebulizer drugs, IV medications for pain management, antiviral drugs, cancer treatments or parenteral nutrients) is not covered by Medicare if the drug is dispensed by an entity that is not licensed to dispense the drug. The drug is not considered to be reasonable and necessary because we cannot be assured of its safety and effectiveness unless it is dispensed by an entity that has a state license that qualifies it to dispense the drug. The equipment used with drugs which are not dispensed by a licensed entity is also not considered to be reasonable and necessary because of related safety and efficacy questions.

The DMERC will deny claims (drugs and equipment) when the files show the supplier is not licensed to dispense prescription drugs. These are medical necessity denials based on section 1862 (a)(1). Routine or blanket waivers are not applicable in this circumstance. Please refer to Chapter 12 of the Region A Supplier Manual for more details on waiver of liability.

If a supplier is providing the related equipment (e.g., nebulizer, infusion pump, parenteral pump) to be used in conjunction with the drugs, it is that supplier's responsibility to check on the licensure of the pharmacy before providing and billing for the equipment. If the pharmacy is unlicensed, the drugs will be denied, therefore, the related equipment may also be denied. Any claims paid to an unlicensed pharmacy will be recouped and payments made to any supplier for the related equipment may be subject to review, denial and recoupment.

A post-payment review of claims for drugs supplied after December 1, 1996 is currently being conducted. To date, relatively few active, unlicensed pharmacies have been identified in Region A.

October 29, 1997 Supplier Notice 97-34

Surety Bonds

The Balanced Budget Act of 1997 requires that each DMEPOS supplier have a surety bond for services furnished on or after January 1, 1998. HCFA is in the process of working out the details of the bonding requirements, which will be promulgated via regulation. Each supplier also will receive notification from the National Supplier Clearinghouse (NSC) as to the supplier's requirements in regard to its bond. These requirements will include the penal (dollar) amount of the bond, deadline for submitting the bond to the NSC, and other specifics such as the time period to be covered by the bond. New suppliers applying after the effective date will be required to have a $50,000 bond that also meets the other requirements. Existing suppliers should have ample time after receipt of this notice to obtain a bond. NO ACTION IS NECESSARY UNTIL YOU RECEIVE NOTIFICATION FROM THE NSC.

Miscellaneous

Supplier Manuals

Supplier Manuals are issued by the DMERC, not the National Supplier Clearinghouse (NSC). The DMERC issues the supplier manuals within 4 to 6 weeks of the supplier receiving their NSC number. Please do not contact the NSC in regard to supplier manuals, contact the Professional Relations Unit at 717-735-9405.

CMNs and Physician Coercion

Physicians have complained to the DMERC of efforts by some suppliers to have them change answers about the medical condition of their patients on certificates of medical necessity (CMNs), or to order items of DME only **after** suppliers have sold them to beneficiaries. Suppliers may not furnish physicians with answers to questions in Section B of CMNs. It is also inappropriate to request physicians to write orders or sign CMNs for items or services which the physician does not deem medically appropriate.

Suppliers are reminded that they **must** furnish narrative descriptions of items delivered to beneficiaries as well as their charges to Medicare and Medicare Fee Schedule allowances in Section C of CMNs, **before presentation to physicians for their review and signature.** The DMERCs are currently conducting audits of CMNs in suppliers' files as well as surveying physicians to ascertain compliance with this statutory requirement (Social Security Act, Section 1834 [j] [2] [A]. Suppliers are subject to civil monetary fines of up to $1,000 per offense (each CMN found to be in non-compliance).

Finally, suppliers should also realize that obtaining a physician signature on a CMN does not guarantee Medicare reimbursement, as medical policy coverage criteria must be fulfilled in addition to the physician's assessment that an item or service is medically necessary.

Phone FAQs (Frequently Asked Questions)

Our customer service personnel receive about 1700-2000 calls from suppliers every day. A large share of these calls pertain to the same questions. The Provider Services Unit has identified these "Frequently Asked Questions" (FAQs) and compiled the list which follows.

We are encouraging all suppliers to carefully consider these questions and answers. It is possible that the very question you're about to call and ask has already been addressed. Finding your answers here will reduce time and money spent on telephone calls to the DMERC.

CHECK THE FAQS BEFORE YOU CALL!!!

1. **How can urological claims be submitted to avoid receiving a CO-125 denial?**

   If a code exists that includes multiple products, that code should be used in lieu of the individual codes to prevent the CO-125. (Supplier Manual; Urologicals pg. 16.9-12)

2. **When should urological multiple product codes be used and not used?**

   Individual or multiple codes should be used when a kit code does not exist for those items which are billed.

3. **Why are my claims for A4357 bedside drainage bag, being denied as not medically necessary when we are only billing for 2 units? The medical policy states that a patient is allowed two per month.**

   Two units of A4357 are allowed with either indwelling or external catheters. When billing for indwelling catheters, a kit code should be billed which will include one drainage bag. The additional drainage bag may be billed separately.

4. **What does it mean when the DMERC says that I have unbundled a code?**

   The Urological policy as published in chapter 16 of the Region A supplier manual contains HCPCS codes that should be used in lieu of individual codes when urological supplies are provided at the same time. Claims received containing multiple codes, where a kit code exists will be considered unbundled and denied.

5. **Why are my oxygen claims being denied CO-97?**

   CO-97 - Contractual Obligations
   Payment is included in the allowance for the basic service / procedure.

   This denial could indicate that the monthly allowable has already been paid for the oxygen system. The Region A DMERC has observed providers billing 2 and 3 times in one month for the same monthly oxygen allowable.

6. **When do I need a recertified oxygen CMN?**

   For Group I, a recertification is required by the 12th month after the initial certification (i.e. by the thirteenth month). For Group II, a recertification with new testing results performed between the 61st and 90th day following the initial certificate is required with the 4th month claim.

7. **What is the timeframe for the last exam date that needs to be on an oxygen claim? Does it need to be a certain period before or after the date initially needed?**

   In initial claims this date should be within a month of both the date that the oxygen was prescribed and the date of the most recent arterial blood gas or oximetry test. When the physician has examined the patient more than one month prior to the order for home oxygen or the most recent testing, determine whether future examinations or tests have been scheduled.

8. **Are new blood gas levels required on a renewal or revised CMN?**

   For Group II oxygen, program requirements require retesting between the 61st and 90th day of home oxygen therapy in order to establish continued medical necessity. Initial certifications and 3 month recertifications must include the results of the most recent arterial blood gas (ABG) or oximetry test. For other recertifications, retesting is not required, but the results of the most recent ABG or oximetry test representing the patient's condition must be included on the CMN.

9. **Why is it required that we need blood gas tests performed at rest when we have quality blood gas test performed while the beneficiary is walking or sleeping?**

   Per the oxygen medical policy, a patient with a blood gas test result to qualify during exercise or sleeping for group I coverage, needs to demonstrate an arterial PO2 at or above 56 or an arterial oxygen saturation at or above 89% while awake, or a greater than normal fall in oxygen level during sleep. The best way to demonstrate this is with test results at rest, during exercise or sleep, and on oxygen during exercise.

10. **Why are my claims for K0265 being denied for no modifier, if I am billing it with an ostomy diagnosis and ostomy supplies?**

    When billing for K0265 with an ostomy product a modifier is not required. These claims are being denied in error. Please contact Provider Services at 717-735-9445 and request an adjustment.

11. **Why are my claims for ostomy supplies being denied for no modifier?**

    Ostomy supplies do not require modifiers. If claims for these supplies were denied for this reason they can be adjusted. Please contact Provider Services at 717-735-9445.

12. **Why are my surgical dressings which have the same code, but different sizes to be billed as one line item?**

    Billing duplicate procedure codes for the same date of service on different line items will result in duplicate denials. See Supplier Notice 97-24, included in this newsletter on pages 33-34.

13. **Suppliers are calling the DMERC to check CMN effective, termination, and renewal dates. Should these calls be made to the DMERC?**

    Suppliers should retrieve this information from the original CMN they have on file, the physician's files, and the beneficiary's records.

14. **If a beneficiary moves from one DMERC region to another, should they use the same CMN even if it is an old version?**

    If a beneficiary moves outside of a region where the billing has initially begun, a new CMN is not always necessary. Circumstances that would warrant obtaining a new CMN would include; if the original CMN is invalid, if a revision or recertification is required or if a new product is ordered. If a new CMN is obtained it must be the current version.

15. **Why are my feeding kits being downcoded if the CMN for the pump is valid?**

    If payment has been made on the pump, the necessary feeding kits should not be downcoded. If this situation occurred, please contact Provider Services at 717-735-9445.

16. **What is the minimum number of supplies in a multiple product code (column I), to be used before it can be billed as the individual code?**

    Whenever multiple products from column II are provided at the same time the corresponding column I code must be used, regardless of the number of units supplied. e.g., If an insertion tray (A4310) and a catheter (A4338) are supplied at the same time, then A4311 is the proper coding for that combination. If 2 A4310's and 2 A4338's are supplied, then 2 A4311's should be billed.

17. **Why are maintenance and service claims for wheelchairs being denied if we have received payment for 15 months?**

    We would need examples to verify when maintenance and service is due. If the claims were denied incorrectly, they can be adjusted.

18. **When does the maintenance and servicing coverage begin on a capped rental?**

    Maintenance and servicing coverage begins six months after the last rental payment. The six month count begins on the month after the fifteenth rental payment. All fifteen rental payments must be made to avoid denials.

19. **What do I need to do in order to get my claims for capped rental items paid when billing for MS and the DMERC claims my company has not received 15 rental payments?**

    Medicare pays for maintenance and service of a capped rental item every six months after the total 15 months of rental have been paid. If 15 months have not been paid, the supplier should determine if all 15 months have been billed. If claims for the monthly rentals have been denied the provider should refer to the EOB (explanation of benefits) for the reason for denial and take the necessary steps to correct the denial.

20. **Why are so many maintenance and service claims being denied CO-30?**

    Claims will deny CO-30 if the maintenance and service claim is billed prior to 6 months after the fifteenth rental month. Example, initial date of service is 1/1/90, fifteenth rental month is 3/1/91, 6 month maintenance and service date is 10/1/91.

21. **What supplies/equipment require a ZX modifier, and when are they to be used?**

Urological, Home Blood Glucose, Support Surfaces, Orthopedic Footwear, and Therapuetic Shoes for Diabetics. The ZX modifier is to be used when the coverage guidelines are met and the supplier has the documentation on file to support its request. Do not use a ZX modifier unless required by the medical policy.

22. **Why doesn't Medicare pay for bathroom medical supplies and equipment?**

Medicare does not pay for bathroom supplies and equipment because they are non-covered items by Medicare.

23. **What items are covered by the DMERC in a Skilled Nursing Facility?**

Orthotics and Prosthetics are covered in a Skilled Nursing Facility (SNF). PEN, Ostomy, Incontinence, Surgical Dressings, and Eyeglasses fall under the prosthetic benefit, and would be eligible for coverage.

24. **If a beneficiary attempts to have a wheelchair paid through Medicare, but is denied, will Medicare pay for repairs if the beneficiary purchases the chair outright?**

Medicare will reimburse for repairs on the beneficiary owned equipment when the repair and the equipment is medically necessary.

25. **Where can I find it in writing that the supplier is required by federal law to complete and submit the 1500 claim form for beneficiaries?**

The Medicare Carriers Manual-3041.A states "Section 1848(g) (4) of the Social Security Act requires physicians and suppliers to submit Part B claims processed by Medicare carriers within one year for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim to Medicare. In addition, payment for assigned services that are not filed within 1 year of the date of service will be reduced by 10 percent. Physicians and suppliers who fail to submit a claim or who impose a charge for completing a claim are subject to sanctions, monetary penalties of up to $2,000 per violation, and / or Medicare program exclusion.

26. **Why were my claims denied for missing information in block 33, when all the required information is there?**

The information must be complete and must match what is on file with the National Supplier Clearinghouse (NSC). Please refer to supplier notice 97-19.

DMERC Medicare News

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