DMERC

Medicare

News

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

Region A DMERC Seminar Registration

Come one, come all! Region A's June seminars will be coming soon to a city near you. Register NOW!

AGENDA

Registration - 8:30 AM - 9:00 AM
Coffee will be served

Seminar - 9:00 AM - 1:00 PM

VIPS

HCFA 1500 Form

CMNs

Electronic Data Interchange (EDI)

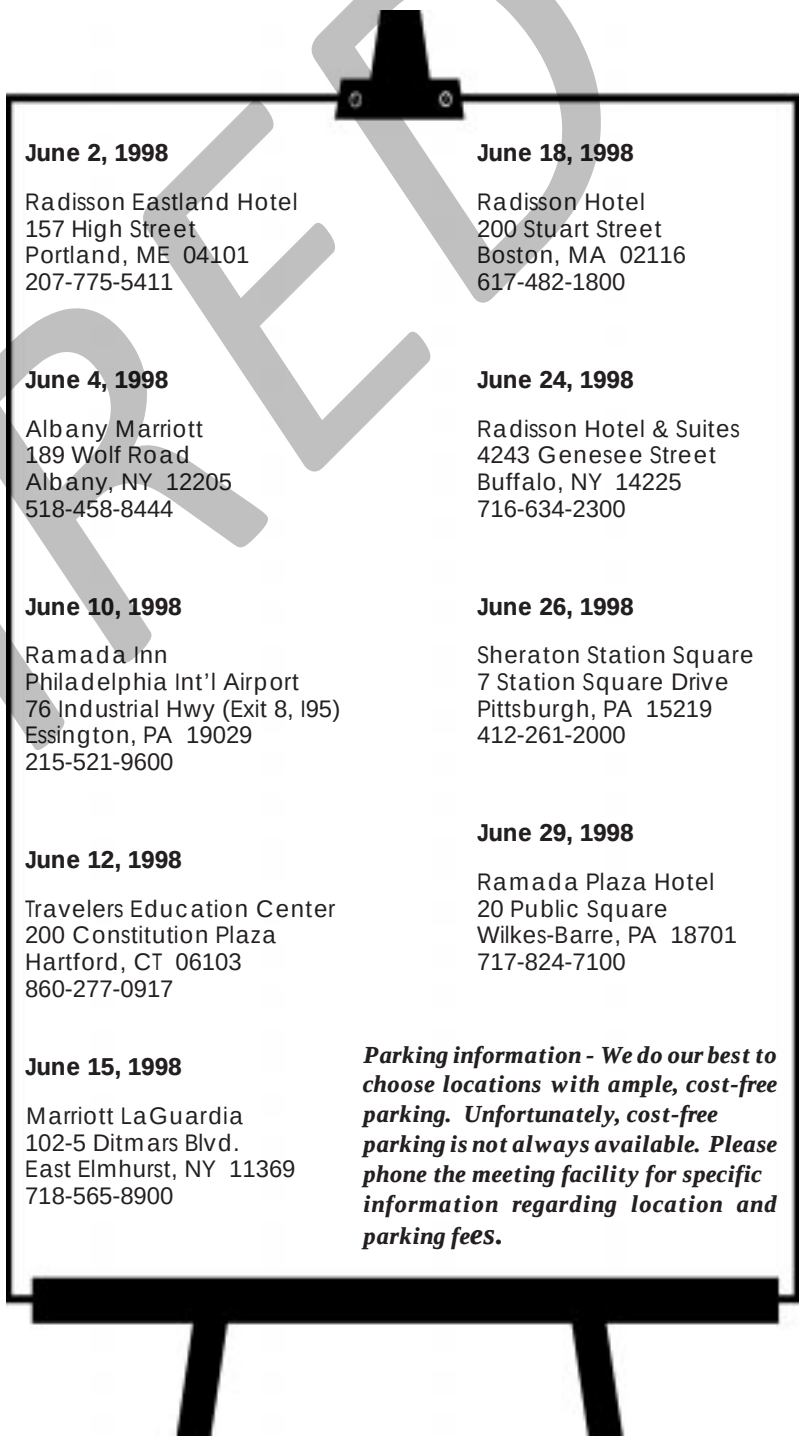
Fraud and Abuse

Please note: There is ***no registration fee*** for this round of seminars. Lunch will not be provided.

All attendees must be pre-registered. Due to limited space, registration is on a first come, first served basis. If a particular seminar is filled to capacity, you will be notified by telephone and given the opportunity to make another selection.

Registrations must be faxed or postmarked by May 15, 1998 for all seminar locations. Any registrations postmarked after that date will be returned to the supplier.

If you do not receive a confirmation within 5 days of the seminar for which you have registered, please call our Professional Relations Unit at 717-735-9406.



June 2, 1998

Radisson Eastland Hotel
157 High Street
Portland, ME 04101
207-775-5411

June 4, 1998

Albany Marriott
189 Wolf Road
Albany, NY 12205
518-458-8444

June 10, 1998

Ramada Inn
Philadelphia Int'l Airport
76 Industrial Hwy (Exit 8, I95)
Essington, PA 19029
215-521-9600

June 12, 1998

Travelers Education Center
200 Constitution Plaza
Hartford, CT 06103
860-277-0917

June 15, 1998

Marriott LaGuardia
102-5 Ditmars Blvd.
East Elmhurst, NY 11369
718-565-8900

June 18, 1998

Radisson Hotel
200 Stuart Street
Boston, MA 02116
617-482-1800

June 24, 1998

Radisson Hotel & Suites
4243 Genesee Street
Buffalo, NY 14225
716-634-2300

June 26, 1998

Sheraton Station Square
7 Station Square Drive
Pittsburgh, PA 15219
412-261-2000

June 29, 1998

Ramada Plaza Hotel
20 Public Square
Wilkes-Barre, PA 18701
717-824-7100

Parking information - We do our best to choose locations with ample, cost-free parking. Unfortunately, cost-free parking is not always available. Please phone the meeting facility for specific information regarding location and parking fees.

IN THIS ISSUE

Please complete and mail this registration form to:

United HealthCare
Attn.: Seminar Registration
PO Box 6800
Wilkes-Barre, PA 18773-6800

or

FAX to: Attn: Seminar Registration
717-735-9442

Registration Form

Company _____

Provider Number _____

Submitter Number (*Billing Services Only*) _____

Address _____

_____

_____

Phone _____

Location of Seminar _____

Number Attending _____

Name of Attendee(s) _____

Contact Name _____

Phone _____ Fax _____

(fold)

Place Stamp Here

United HealthCare
Attn: Seminar Registration
PO Box 6800
Wilkes-Barre, PA 18773-6800

(tape or staple here)

Medical Policy

Ask the Doc

Your questions are important to us. In our continuing effort to provide better communication between Medicare and you, "Ask the Doc" will be a featured article in each issue of the *DMERC Medicare News.* If you are interested, please suggest certain medical policy concerns to be considered for publication in this column. Send these issues to:

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

Upon review of your suggestions, the Medical Director will select the topics to be featured.

Fecal Fat Testing for Malabsorption

The DMERC RMRP for parenteral nutrition discusses results obtained from the 72 hour fecal fat test as documentation to determine coverage of parenteral nutrition under the prosthetic benefit. This is a quantitative test which is used to establish the diagnosis of malabsorption. In this test, the patient is placed on a controlled diet containing a specified amount of fat, all stools are collected over a 72 hour period, and analysis of the entire stool specimen for fat content is performed by a qualified laboratory. When the quantitative amount of fat found within the 72 hour collection of stools is high enough, it may document the condition of malabsorption adequately, when accompanied by other signs, symptoms and diagnoses consistent with this condition.

The policy also establishes criteria for the determination of malabsorption when lesser amounts of fat are found in stools using the 72 hour fecal fat test, or when using other less quantitative but still established tests of malabsorption, in combination with a tube trial. Examples of less quantitative tests for malabsorption, such as sudan staining of stools for fat and the d-xylose test, are listed in the policy.

Some tests for stool fat, whose validity has not been established in the medical literature and whose results cannot be reliably correlated with the standard 72 hour fecal fat test, are being submitted to the DMERC to document the condition of malabsorption. These unproven tests involve collection of single random stool samples after dietary interventions involving patients taking extra amounts of olive oil which will increase the resulting stool fat content. Such tests, which are not evaluated in peer reviewed literature, will not suffice as adequate documentation to establish the condition of malabsorption as defined in the published DMERC policy, when used as substitutes for standard tests of malabsorption.

Cervical Traction - Code E0855

Effective with dates of service on or after January 1, 1998, a new code, E0855, was established with the description: "Cervical traction equipment not requiring additional stand or frame." The DMERCs have determined that the medical evidence submitted to them is not sufficient to establish any increased effectiveness of the known products included in this code compared to a standard over-the-door cervical traction device (E0860). Therefore, for dates of service on or after January 1, 1998, payment for code E0855 will be based on the allowance for the least costly medically appropriate alternative, E0860.

At the present time, the known products that should be billed using this code are the Pronex pneumatic traction device manufactured by Glacier Cross and the Saunders Cervical HomeTrac manufactured by The Saunders Group. If a supplier or manufacturer thinks that another product meets the description of the code, they may contact the Statistical Analysis DME Regional Carrier (SADMERC) for a written coding determination.

Faxed CMNs

The DMERCs have received many questions about whether faxed Certificates of Medical Necessity (CMNs) are considered valid forms for suppliers to use when preparing claims for submission to the DMERC. A supplier must send a double-sided CMN to the physician for their signature and obtain back a signed hardcopy of that double-sided CMN from the physician. If the supplier needs the CMN on an urgent basis, the supplier may receive a faxed copy of the original CMN from the physician. However, the supplier must subsequently receive for their files the signed, hardcopy, original CMN from the physician.

Correction: Refractive Lens Codes V2107 and V2530

An error was noted in the verbiage for codes V2107 and V2530 published as part of the Refractive Lens policy in the December 1997 *Supplier Manual* Update.

In the policy, V2107 and V2530 read as follows:

V2107-Spherocylinder, single vision, plus or minus 4.25D to plus or minus 7.00 sphere, .12 to 2.00D cylinder per lines.

V2530-Contact lens, scleral, per lens.

The **correct** descriptors for V2107 and V2530 are as follows:

V2107-Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, .12 to 2.00D cylinder, per lens.

V2530-contact lens, scleral, gas impermeable, per lens.

The policy which contains these codes is effective for claims with dates of service on or after March 1, 1998. It is a revision to a previously published policy.

Timeliness of Oxygen Testing

Use of the new oxygen Certificate of Medical Necessity (DMERC 484.2) will become mandatory April 1, 1998. The instructions printed on the reverse of the new form are consistent with those printed on other DMERC CMNs. It is important to note that instructions on the previous form tell physicians and suppliers that blood gas determinations used to qualify beneficiaries for the oxygen benefit must be done within 30 days prior to the initial certification for all oxygen claims. Additionally, for beneficiaries who initially qualify for oxygen coverage with Group II blood gases, or for those whose doctors' estimated length of need is less than lifetime, repeat blood gas determinations must be performed within 30 days prior to recertification. Although the form design is new, these requirements for timely blood gas determinations have not changed.

Pricing

1998 New Codes and Allowables

Codes A4462, L1843, and L5614 are new in 1998.

	A4462	L1843	L5614
CT	3.13	392.81	3221.67
DE	3.13	392.81	3185.20
MA	3.13	392.81	3221.67
ME	3.13	392.81	3221.67
NH	3.13	392.81	3221.67
NJ	3.13	392.81	3084.18
NY	3.13	392.81	3084.18
PA	3.13	392.81	3185.20
RI	3.13	392.81	3221.67
VT	3.13	392.81	3221.67

Miscellaneous Code Reminder

When submitting claims to the DMERC for items using any miscellaneous code, as a general rule, include a complete descriptor, including manufacturer name, product name/model number and the medical necessity of the item for the patient. For any additional documentation requirement for any particular miscellaneous code, consult the Documentation Section of the Regional Medical Review Policy for which it applies. When billing for prosthetic and orthotic items using miscellaneous codes, also include the manufacturer's invoice showing the retail cost. If the invoice is not available, submit the wholesale cost as well as the above items. Failure to furnish the above may result in denial.

A4335	B9999	J8999	L3999	V2399
A4421	E1399	K0108	L4210	V2499
A4649	E1699	K0415	L5999	V2599
A4913	J3490	K0416	L7499	V2629
A5149	J7599	K0448	L7510	V2799
A6261	J7699	L1499	L8499	
A6262	J7799	L2999	V2199	
B9998	J8499	L3649	V2299	

Initial Notice of Inherent Reasonableness

The Region A DMERC has reviewed the Local Carrier base fees for HCPCS code E0185 (gel or gel-like pad for mattress) and determined that they are either deficient or excessive. The information that follows reflects our proposed changes for your review.

The law, under §1842 (b)(8)(A) of the Social Security Act, allows the application of inherent reasonableness to reasonable charges that are determined to be either grossly excessive or grossly deficient. The 1989 local carrier base fees were developed using either 1986 reasonable charge data or gap-filling. Therefore, revisions to establish a realistic and equitable fee must be applied to the 1986 data. Our base fee revisions are derived using retail catalog price lists for this same period. If sources are not available, we use the earliest available catalogs that contain sources for codes under review.

The revised base fees will be indexed to the 1998 fee screen year using the annual covered item update factors below. In addition, national floor and ceiling limitations will be applied prior to establishing the final fees.

Covered item update factors are as follows:

	DME/Other	P&O
1989	1.7%	1.7%
1990	0.0%	0.0%
1991	3.7%	0.0%
1992	3.7%	4.7%
1993	3.1%	3.1%
1994	3.0%	0.0%
1995	2.5%	0.0%
1996	3.0%	3.0%
1997	2.8%	2.8%
1998	0.0%	1.0%

You have thirty days to submit any comments regarding these changes. Your comments must be received by May 1, 1998. Remember, it is not the Health Care Financing Administration's intention to pay for deluxe or personal comfort items. When submitting comments include supporting documentation that best reflects the 1986/1987 historical charge data base period. Please send all comments to:

Pricing Unit
Inherent Reasonableness
United HealthCare
PO Box 6800
Wilkes-Barre, PA 18773-6800

The inherent reasonableness charges for HCPCS code E0185, Gel or gel-like pressure pad for mattress are as follows:

Code	State	Current 1998 Base Fee	Revised 1998 Base Fee	Proposed 1998 Allowance
NU	CT	$144.92	$179.37	$222.32
	DE	$432.23	$179.37	$222.32
	MA	$345.00	$179.37	$222.32
	ME	$345.00	$179.37	$222.32
	NH	$350.87	$179.37	$222.32
	NJ	$ 60.00	$179.37	$222.32
	NY	$479.69	$179.37	$222.32
	PA	$210.22	$179.37	$222.32
	RI	$290.03	$179.37	$222.32
	VT	$350.87	$179.37	$222.32
RR	CT	$102.56	$ 17.94	$ 22.24
	DE	$ 62.65	$ 17.94	$ 22.24
	MA	$ 34.58	$ 17.94	$ 22.24
	ME	$ 34.58	$ 17.94	$ 22.24
	NH	$ 34.58	$ 17.94	$ 22.24
	NJ	$ 60.00	$ 17.94	$ 22.24
	NY	$ 47.96	$ 17.94	$ 22.24
	PA	$ 51.29	$ 17.94	$ 22.24
	RI	$ 31.64	$ 17.94	$ 22.24
	VT	$ 34.58	$ 17.94	$ 22.24
UE	CT	$119.24	$134.53	$166.72
	DE	$324.17	$134.53	$166.72
	MA	$258.75	$134.53	$166.72
	ME	$258.75	$134.53	$166.72
	NH	$263.15	$134.53	$166.72
	NJ	$ 60.00	$134.53	$166.72
	NY	$359.77	$134.53	$166.72
	PA	$210.22	$134.53	$166.72
	RI	$217.52	$134.53	$166.72
	VT	$263.15	$134.53	$166.72

The proposed 1998 fee is the end result of calculations previously described. These are not the final fees for 1998. Final fees will be limited by the national floors and ceilings.

Parenteral and Enteral Nutrition (PEN)

1998 HCPCS codes and fees for parenteral and enteral nutrition are as follows:

HCPCS	MOD1	MOD2	FEE
B4034			5.60
B4035			10.67
B4036			7.31
B4081			19.78
B4082			14.73
B4083			2.25
B4084			17.03
B4085			37.48
B4150			0.61
B4151			1.43
B4152			0.51
B4153			1.74
B4154			1.12
B4155			0.89
B4156			1.24
B4164			15.08
B4168			21.96
B4172			IC
B4176			38.25
B4178			51.04
B4180			21.61
B4184			70.86
B4186			94.48
B4189			157.66
B4193			203.73
B4197			248.02
B4199			298.43
B4216			6.85
B4220			7.10
B4222			7.89
B4224			22.19
B5000			10.54
B5100			4.12
B5200			5.68
B9000	NU		1121.97
B9000	RR		103.10
B9000	UE		841.47
B9002	NU		1121.97
B9002	RR		108.66
B9002	UE		841.47
B9004	NU		2238.01
B9004	RR		354.30
B9004	UE		1678.51
B9006	NU		2238.01
B9006	RR		354.30
B9006	UE		1678.51
E0776	NU	XA	93.30
E0776	RR	XA	23.62
E0776	UE	XA	29.15

IC = Individually Considered

Note: The allowances listed may not reflect suppliers' allowances. Medicare calculates the allowances for each procedure code listed above by selecting the lowest of the following: the prevailing charge, the lowest charge level prevailing, the suppiliers' customary charge, the inflation index charge, or the actual charge.

Listing of HCPCS Codes by Proper Payment Categories

Following the publication of the 1998 Fee Schedule, we received comments from suppliers that they are unable to determine the appropriate payment category for items being billed. For that reason, we have developed the following table to provide this information. Please be advised that this list is not all inclusive.

Capped Rental Items	Frequently Serviced Items	Inexpensive and Routinely Purchased Items	Ostomy, Tracheostomy, and Urologicals	Oxygen	Supplies	Surgical Dressings	TENS
E0145-E0146	E0450	A4254	A4214	E0424	A4221-A4222	A4460	E0720
E0165-E0166	E0453	A4611-A4613	A4310-A4316	E0431	A4253	A4462	E0730
E0180-E0182	E0457	A4618	A4320-A4323	E0434	A4255-A4256	A6154	
E0186-E0187	E0460	A4628	A4326-A4330	E0439	A4258-A4259	A6196-A6197	
E0193-E0194	E0575	A4635-A4637	A4340	E0455	A4556-A4558	A6199	
E0196	E0935	A4640	A4344	E0555	A4595	A6203-A6204	
E0202	K0455	E0100	A4346-A4347	E0580	A4624	A6207	
E0218		E0105	A4351-A4359	E1400-E1406	E0731	A6209-A6212	
E0235-E0236		E0110-E0114	A4361-A4365	E0441	E1701-E1702	A6214	
E0250-E0251		E0116	A4367-A4368	E0442	K0110-K0111	A6216-A6217	
E0255-E0256		E0130	A4397-A4400	E0443	K0283	A6219-A6220	
E0260-E0261		E0135	A4402	E0444		A6222-A6224	
E0265-E0266		E0141-E0143	A4404			A6229	
E0277		E0147	A4454-A4455			A6234-A6238	
E0290-E0297		E0153-E0164	A4481			A6240-A6248	
E0305		E0167	A4622-A4623			A6251-A6255	
E0371-E0373		E0175-E0179	A4625-A4626			A6257-A6259	
E0452		E0184-E0185	A4629			A6263-A6266	
E0459		E0191-E0192	A5051-A5055			A6402-A6403	
E0462		E0197-E0200	A5061-A5063			A6405-A6406	
E0480		E0205	A5071-A5073			K0154	
E0550		E0210	A5081-A5082			K0196-K0197	
E0565		E0215	A5093			K0199	
E0570		E0217	A5102			K0203-K0204	
E0585		E0220	A5105			K0207	
E0600-E0601		E0225	A5112-A5114			K0209-K0212	
E0606		E0230	A5119			K0214	
E0608		E0237-E0239	A5121-A5123			K0216-K0217	
E0630		E0249	A5126			K0219-K0220	
E0635		E0271-E0272	A5131			K0222-K0224	
E0744-E0745		E0275-E0276	K0137-K0139			K0229	
E0749		E0280	K0277-K0281			K0234-K0238	
E0781		E0310	K0407-K0411			K0240-K0249	
E0791		E0325-E0326	K0419-K0439			K0251-K0255	
E0910		E0370	XX004-XX007			K0257-K0259	
E0920		E0560	XX011			K0263-K0266	
E0930		E0605				K0402-K0403	
E0940-E0941		E0607				K0405-K0406	
E0946		E0609-E0610					
E0958		E0615					
E0968		E0621					

Capped Rental Items	Frequently Serviced Items	Inexpensive and Routinely Purchased Items	Ostomy, Tracheostomy, and Urologicals	Oxygen	Supplies	Surgical Dressings	TENS
E1031		E0627-E0629					
E1050		E0650-E0652					
E1070		E0660					
E1083		E0665-E0669					
E1084-1093		E0671-E0673					
E1100		E0690					
E1110		E0747					
E1130		E0748					
E1140		E0776					
E1150		E0782-E0783					
E1160		E0840					
E1170-E1172		E0850					
E1180		E0855					
E1190		E0860					
E1195		E0870					
E1200		E0880					
E1210-E1213		E0890					
E1221-E1225		E0900					
E1228		E0942-E0945					
E1240		E0947-E0948					
E1250		E0950-E0954					
E1260		E0959					
E1270		E0961-E0967					
E1280		E0969-E0980					
E1285		E0990-E1001					
E1290		E1065-E1066					
E1295		E1069					
E1800		E1226-E1227					
E1805		E1230					
E1810		E1296-E1298					
E1815		E1310					
E1825		E1372					
E1830		E1375					
K0001-K0004		E1700					
K0006-K0007		E1820					
K0010-K0012		K0005					
K0101		K0015-K0100					
K0193-K0195		K0102-K0107					
K0269		K0114-K0116					
K0270		K0168-K0175					
K0284		K0176					
K0413-K0414		K0177-K0192					
K0454		K0268					
K0501		K0417					
		K0452					
		K0530					
		L3964-L3966					
		L3968-L3970					
		L3972					
		L3974					

All L codes and Facial Prosthesis codes (K0440-K0451) are in the prosthetic and orthotic category except the following which are in the inexpensive and routinely purchased category.

L3964-L3966
L3968-L3970
L3972
L3974

Correction - HCPCS Code L2035

The December 1997 issue of the *DMERC Medicare News* contained a typographical error. On page 7, HCPCS code L2035 was inadvertently published as L0235. Please make the correction to your newsletter.

Discontinued Oral Anti-Cancer Drugs

The following 2 NDC numbers have been discontinued effective for dates of service on or after January 1, 1998:

- 51432-0522-03 Methotrexate 2.5mg oral,1 tab, per unit manufactured by Roxanne
- 58469-3998-30 Methotrexate 2.5mg oral,1 tab, per unit manufactured by Roxanne

Medicare Approved Products

It has been brought to our attention that some manufacturers and suppliers advertise their particular product as *Medicare Approved* since the product is represented by a particular HCPCS code. This is an incorrect statement. When a manufacturer or a supplier requests a new HCPCS code from the SADMERC for a particular item, the SADMERC, in conjunction with the four DMERCs, determines if an existing code appropriately describes the product. If no such code currently exists, the SADMERC decides if a new code is needed or if the use of a not otherwise classified code is appropriate. It is important to note, however, that a HCPCS code is not indicative of Medicare coverage or payment.

Supplier Notices

December 9, 1997
Supplier Notice 97- 35

Addition to Supplier Notice 97-29
Date of Service/Date of Delivery/Date of Discharge

This notice serves as a continuance to the previously issued Supplier Notice 97-29, "Date of Service / Date of Delivery / Date of Discharge," dated August 25, 1997. All information as published in Supplier Notice 97-29, in addition to the below, is applicable in reference to this issue.

As a result of Supplier Notice 97-29, the DMERC received several requests for clarification:

1) Can a supplier deliver DME to a hospital or nursing home to facilitate a discharge?

DME can be delivered to a facility (i.e., hospital or nursing home) on the **same day** as the date of discharge for the patient to take home, in order to facilitate the discharge. Equipment may not be delivered for use at or by the facility.

a) How should the "place of service" be documented on the claim generated to the DMERC when the equipment is delivered on the date of discharge?

Place of service 12 (home) would be documented on the claim when equipment is delivered to the facility on the same day the patient is discharged to go home.

b) Can a supplier deliver equipment to a customer's home prior to the date of discharge (i.e., bed, trapeze, commode, etc.)? What date should be on the claim generated to the

DMERC as the "date of service" - the actual date of delivery or the date of discharge? How should the supplier document this - (i.e., billing chart or HA0 record) or both? How should "place of service" be documented on the claim.

As stated in Supplier Notice 97-29 - "This should not be a routine practice." However, circumstances may exist which require the equipment to be delivered or shipped to the **patient's home,** prior to discharge, for **immediate** use upon their arrival home. In these situations, the date of service would be the final date of discharge and the place of service would be 12 (home). Documentation/information relating to such circumstances must be retained in the supplier's records and available to the DMERC if requested. It does not need to be reported in the HA0 record or on the claim. **Delivery of DME to a facility for beneficiary's use, prior to the date of discharge, is not acceptable**. Supplier Notice 97-29 states - "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. 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."

c) **If the equipment is delivered on the scheduled day of discharge, then the actual discharge date is changed after the delivery due to medical or other complications (i.e., patient spikes a temperature), how should this be documented?**

Documentation from the hospital should be obtained by the supplier (i.e., copy of discharge summary/record) to establish a paper trail of the events from the original scheduled date of discharge up to the final date of discharge. In such circumstances, the final date of discharge to the patient's home would be used as the date of service on the claim to the DMERC, with place of service 12 (home). The documentation would be retained in the supplier's records and available to the DMERC if requested.

2) **As stated in Supplier Notice 97-29 "For mail order DMEPOS provided immediately subsequent to a hospital inpatient stay and/or DME immediately following a nursing home stay, the Date of Service (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 case of mail order DMEPOS, the shipping date." Since the DOS can be changed to the discharge date on mail order, can the DOS be changed to the discharge date for equipment delivered to the hospital, nursing home or home?**

The date of service normally is the date of delivery or shipping date. Exceptional circumstances where the discharge date could perhaps be used as the date of service are described in our response to question 1(b). Outside of these exceptional situations, the date of service **is** the date of delivery or the shipping date.

3) **Can the DME be delivered to the hospital prior to the patients discharge date for evaluation purposes by the medical staff? (i.e.: wheelchair and ventilators)**

The critical issue is the date the patient takes possession of the equipment. Possession will generally be determined by the date the patient accepts the equipment, as shown on the delivery slip. If the **patient takes possession prior to discharge the DME is NOT covered**.

a) What would be considered appropriate documentation to have on record for billing purposes?

A patient signed delivery ticket that the DME equipment was provided to the patient (ownership transferred) **on the date of discharge.**

January 6, 1998 Supplier Notice 98-01

Clarification - Group I and Group II Pressure Reducing Support Surfaces

It has come to our attention that erroneous information may have been distributed by entities other than the DMERC concerning documentation for Group I and Group II support surfaces.

According to the Pressure Reducing Support Surfaces - Group I and Group II medical policy documentation sections, "Questions pertaining to medical necessity on any form used to collect this information may not be completed by the supplier or anyone in a financial relationship with the supplier."

This statement can be found under the documentation requirements on pages 14.22-6 and 14.23-6 of the *Region A Supplier Manual.*

January 6, 1998 Supplier Notice 98-02

Clarification - Waiver of Liability

It has come to our attention that erroneous information may have been given out by entities other than the DMERC concerning Waiver of Liability procedures.

The decision as to whether the beneficiary or supplier are entitled to limitation of liability will be made at the time of initial claims adjudication. The supplier may obtain an advance notice and agreement to pay from the beneficiary prior to submitting the claim. The waiver letter must be kept on file by the supplier. The claim should be annotated with a GA modifier to show that such a notice was given.

Waiver of liability agreements may not be obtained at the review level or at the fair hearing level. They must be obtained prior to initial claim submission.

Waiver of liability information can be found on pages 12-7 through 12-11 in the *Region A Supplier Manual.*

February 23, 1998 Supplier Notice 98-03

Same/Similar Equipment

The Region A DMERC has recently implemented revised guidelines for Same / Similar equipment claims. Beneficiaries and suppliers alike are well acquainted with the difficulties which have accompanied claims for these items. This revision will potentially reduce initial denials on these types of claims.

Please review the examples which follow:

The current equipment is within its 15 month capped rental period and new equipment represented by the same code is billed.

If the new Certificate of Medical Necessity (CMN) is valid, payment will be allowed on the new item for the remaining months of the capped rental period. Payment will cease on the previous equipment. Proof of pick-up of the previous equipment will not be required. A new capped rental period will not begin. *(For example, K0001 to K0001.)*

The current equipment is within its 15 month capped rental period and the new equipment has a procedure code different from the previous item. The CMN questions for both items require identical answers to indicate medical necessity.

If the CMN of the new item is valid, payment will be allowed on the new item for the remaining months of the capped rental period. Payment will cease on the previous equipment. Proof of pick-up of the previous equipment will not be re-

quired. A new capped rental period will not begin. *(For example, K0001 to K0002.)*

The current equipment is within its 15 month capped rental period and a new higher level item, represented by a different code is billed. The coverage and payment criteria for the new item are different from that of the previous item.

A. If the CMN for the new upgraded item is valid, payment will be made according to the appropriate payment category.

   1. If the new item is classified as a capped rental, a new 15 month rental period will be approved. *(For example, K0001 to K0003.)*

   2. If the new item is available for and billed as a purchase, payment will be made accordingly. Payment will cease on the previous equipment. Proof of pick-up will not be required. *(For example, K0004 to K0011.)*

B. If the CMN for the new item is not valid, but does document medical necessity for a lower level item, payment will be based on the least costly medically appropriate alternative (downcoding).

   1. If this downcoding results in the same code as the previous item, payment will be allowed on the new item for the remaining months in the capped rental period. Payment will cease on the previous equipment. Proof of pick-up will not be required. A new capped rental period will not begin. *(For example, the previous item is a K0001. The new item is a K0004, but it is downcoded to a K0001.)*

   2. If this downcoding results in a code different from the previous item, payment will be allowed according to the appropriate payment category for the code which resulted due to the downcoding. Payment on the previous item will cease. Proof of pick-up will not be required. A new capped rental period will not automatically begin unless the code which resulted due to the downcoding represents an upgraded item with coverage criteria different from the previous item. *(For example, the previous item is a K0001. The new item is a K0005 billed as a rental, but downcoded to a K0004. A new capped rental would be allowed for the K0004.)*

Please Note: If the new item is billed as a purchase, and downcoding would place the item in the capped rental category, downcoding will not occur. Payment for the new item will be denied, as capped rental items may not be purchased initially. For example, a K0005 is billed as a purchase, but medical necessity is met for a K0004. The K0005 will be denied and not downcoded to the K0004.

When the new equipment being billed is a lower level piece of equipment than the previous item, even though the CMN for the new item may be in accordance with medical policy criteria, the claim must be accompanied with additional documentation. Payment and a new capped rental period will only be considered with a suitable explanation of the change in the beneficiary's condition and of the downgrade in equipment.

Same/similar equipment denials will be issued if Medicare records indicate the purchase of or a completed capped rental for any piece of equipment which serves the same or similar medical purpose as the new item being billed. Payment and a new capped rental period would only be considered with information showing the return of the prior equipment along with additional medical necessity documentation which would warrant the need for the new piece of equipment.

The above examples are not representative of all potential situations.

Additional documentation for upgrades in equipment will not be routinely required.

For further details, please contact the appropriate Product Focus Ombudsman at (717) 735-9666.

Electronic Data Interchange

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.

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 vendor's 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.

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.

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

Electronic Remittance Notices (ERN Version 2.01)

Effective July 1, 1998 Region A DMERC will support Version 2.01 of the ERN National Standard Format. If your vendor requires a copy, please contact Team EDI. The Region A DMERC will continue to return ERN files in version 1.04 or 2.00.

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

Medicare email address
dmerca@ix.netcom.com

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. This charge of $15.00 began with the new version of Accelerate which became available mid October 1997. This version incorporates version 3.01 of the National Standard Format, along with the latest CMN revisions. The new versions of the CMN had an implementation date of October 1, 1997. As an option, you may continue to submit the old CMNs with the old version 2.0 software until the mandatory cut off date of March 31, 1998. If you wish to receive the latest version of Accelerate, please complete the order form and return it to us with a check for $15.00 made payable to **United HealthCare**. The Region A DMERC will not issue the Accelerate software until payment is received. Only one software package will be mailed to each submitter, so please order the correct disk size. Questions regarding this statement or the software may be directed to the **E**lectronic **D**ata **I**nterchange Help Desk at (717) 735-9429.

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.

Options to Check Claim Status

Two options are available for checking claims status:

- **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 allows 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 these options, contact the EDI Help Desk.

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 to 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

Since May 1, 1997, test results are no longer 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.

Note: United HealthCare will no longer accept faxed copies of the EDI enrollment form.

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.

Hearings

Hearing Request Status

If it is necessary to check the status of a hearing request, please provide the case number as indicated on your acknowledgment letter. If your question is with respect to specific beneficiaries contained in a multiple issue case, you should identify each beneficiary with their respective HIC number. Normally the information which you are seeking must be researched and is not readily available should you call. If possible, send your written inquiry to:

United HealthCare
Attn: Hearings Unit
Region A DMERC
PO Box 6800
Wilkes-Barre, PA 18773-6800

Hearing Analysis Results

During a recent analysis project, the Region A DMERC Hearing Unit determined that the primary reason for reversals is due to new evidence presented with the hearing request. In many cases, this documentation was available to the supplier at the time the claim was appealed to review. Perhaps, more interesting is the fact that the data was often available, but not sent with the initial submission. The importance of providing all pertinent documentation as early as possible in the claims adjudication process cannot be emphasized enough. Doing so will allow eligible claims to be approved prior to the appeals process.

Hearing and ALJ Request Forms

We have developed two request forms for your convenience. While use of these forms is not mandatory, it is recommended. Many requests are received which lack important information required to process the request. This causes unnecessary delays. When filled out completely, these forms contain the necessary information to expedite your requests. Should you choose to use another form, please be certain to include all pertinent information as directed on these forms.

A copy of the Hearing Request form was published in the July *DME Medicare News*, No. 34, page 29. A sample format of the Administrative Law Judge Hearing Request form follows.

DMERC Region A
Administrative Law Judge Hearing Request Form

We are dissatisfied with the Hearing Officer's decision in Case # _____.

We are requesting an ALJ hearing.

Supplier Name _____ NSC Number _____

Phone Number _____ Supplier Contact _____

Beneficiary Name	HIC Number	Control Number	Date of Service

Signature _____ Date ____/____/____

Fraud and Abuse

Information Requests

From time to time we are contacted by various HME publications for information on industry issues. In certain circumstances we are unable to respond due to the sensitivity level of some topics or simply due to time constraints. When given ample notice, we make every attempt to supply information which represents our perspective and will be beneficial to our customers.

Assignment Violation

The Program Integrity Department continuously receives a large volume of complaints in regard to assignment violations. It appears that many suppliers (either participating or non-participating accepting assignment) are charging Medicare beneficiaries up-front for the full cost of what is being supplied. The claims are then billed to Medicare, in most cases assigned. Medicare then pays the supplier, in some cases the supplier reimburses the beneficiary what Medicare has paid them. This is not always the correct amount. The beneficiary is only responsible for deductible, co-payment and non covered services.

If you are unsure of your participation status you may contact the National Supplier Clearinghouse (NSC). The NSC handles updating this information.

When a supplier chooses the assigned method of payment on a Medicare claim, they agree to accept the carrier's determination of the allowable charges for a service as *full charge* for that service. This means that, for services covered under the assignment, the physician or supplier cannot bill the patient for any more than the difference between the allowable charge determined by the carrier and the payment received from the carrier.

If a physician or supplier collects more than the applicable deductible and coinsurance for covered services, it will be considered an assignment violation, even if the amount collected is shown on the claim or the excess is promptly refunded once the physician or supplier receives the Part B payment.

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. *(Refer to Supplier Notice 97-09 for further information on billing for deluxe feature.)*

The law now provides that any person who knowingly, willfully, and repeatedly violates the assignment shall be guilty of a misdemeanor subject to a maximum fine of $2,000.00 and/or six (6) months imprisonment.

We must also inform you that the Inspector General has the authority to apply sanctions (civil monetary penalties and/or exclusion from the program) if a provider continues to bill their services incorrectly to Medicare.

The Omnibus Budget Reconciliation Act of 1980 (P.L. 101-239) includes a requirement that physicians and suppliers complete and submit Part B claims for services furnished to Medicare beneficiaries on or after September 1, 1990. The requirement that physicians and suppliers submit all Part B claims was included in Public Law 101-239 as an aid to Medicare beneficiaries, and to improve the completeness and timeliness of claims processed by Medicare carriers. The law specifically forbids you from charging patients for completing or submitting Medicare claims on their behalf.

Charges billed to Medicare should accurately reflect the charges for the items supplied to the Medicare beneficiary. The beneficiary should clearly understand what items are not covered by Medicare and what they will be responsible for paying. Waivers should be signed when applicable and the appropriate use of the GA modifier applied. *(Refer to Supplier Notice 98-02 for further details.)*

Monthly exclusion updates are posted on their web site in the same data format as the CSR, as are separate data files containing individuals and entities that have been reinstated each month. Please refer to the instruction sheet located on their web page for further instructions in using these files.

To access the CSR, point to:

http://www.dhhs.gov/progorg/oig

Provider/Supplier Sanctions

The Department of Health and Human Services, Office of Inspector General has issued the monthly report of health care exclusions and reinstatements.

The report lists providers in the Region A ten-state area who are being excluded from participation in the Title XVIII (Medicare) Program.

This means any claims that are billed to Medicare, which were rendered or referred by any of these physicians and suppliers, **are not** payable by the Medicare program.

There are three different methods to access the listing of sanctioned providers:

1. Electronic submitters can download the file from our Bulletin Board System.

2. The report can be down- loaded from our web page:

   www.medicare-link.com

3. Cumulative Sanction Report

   The Cumulative Sanction Report (CSR) and monthly updates are located on the Department of Health and Human Services, Office of Inspector General's (OIG) World Wide Web Site. The CSR is produced by the Office of Investigations of the OIG.

The CSR is available in DBF format, a database file which allows the user to download the information to a personal computer and import it to a database such as dBASE or Access. An instruction sheet, a record layout, and a list of the sections of the Social Security Act under which exclusions are imposed are also available at their web site.

Claim Entry

RT/LT Modifiers

There have been several policies published that instruct suppliers to use the RT and/or LT modifier to insure proper payment. These policies include:

Ankle-Foot/Knee-Ankle-Foot Orthosis
Recumbent Ankle Positioning Splints
Refractive Lenses
Therapeutic Shoes

Effective with this notice, assigned claims with HCPCS codes submitted for one of these policies without the appropriate RT or LT modifiers will be rejected as an invalid code. Any future policies that require the use of the RT/LT modifiers will be processed in the same manner.

OCNA Number Change

The previous OCNA number 02171B002 was terminated effective October 9, 1997. The correct OCNA number is 02171B001.

Blue Cross Blue Shield of Massachusetts
Medex Department, 8th Floor
100 Hancock St.
North Quincy, MA 02171

DMERC Medicare News

United HealthCare Insurance Company • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800