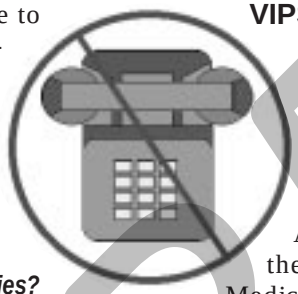
DMERC
Medicare
News

DMERC Region A Service Office • 60 East Main Street • Nanticoke, PA 18634-1685 • Phone (717) 735-9445

Where Do I Go For Info?

There are several options that a supplier can use to access DMERC claim-specific or general information. To help you make the most of what is available, we have listed a few ways which may assist you in getting this needed information.



Supplier Manual

Do you know where to go for coding information?
Do you know where to locate the DMERC Medical Policies?
Do you have questions on how to complete the HCFA-1500 form?
Do you need information for denial resolution?

Have you checked your *Supplier Manual*? Many of the answers to the questions addressed to our Customer Service Representatives can be found in the *Supplier Manual*. It contains information on:

- Contacts, Telephone Numbers, Addresses
- Supplier Enrollment and Standards
- HCFA-1500 Form
- Crossover
- HCFA Common Procedure Coding System
- Pricing
- Medicare Secondary Payer
- Appeals and Hearings
- Fraud and Abuse
- System Outputs
- Electronic Media Claim
- Medical Overview
- Medical Policies

The DMERC publishes periodic revisions to the *Supplier Manual* to keep you up to date on information that has changed. It is important that any revisions be incorporated into your *Supplier Manual* upon receipt. The manual is a very useful tool that should be your first stop for information.

VIPS Provider Inquiry System (VPIQ)

How many claims do I have pending?
Is my claim processing for payment?
Will it be denied?
When can I expect payment on these claims?

Are you asking these questions? If so, VPIQ is the way to go. This new subsystem of the VIPS Medicare System (VMS) will enable you to get answers to these questions. VPIQ is a free system that is accessed through a low cost phone number. It contains valuable information that will be available to you immediately and can be utilized from approximately 6 am to 9 pm, Monday through Friday.

You can obtain:

- Summaries and listings of all pending claims
- Claim status by HICN and date of service
- Paid / denied claim information
- Information on completed claims awaiting payment floor clearance
- Estimated mail or EFT date on completed claims

Not enough? If you are a **participating supplier** you also have the advantage of obtaining eligibility information. Do you need to know when Medicare became effective for a beneficiary? Is their deductible met for the year? Do they have HMO membership? Is there any MSP activity for this beneficiary? The answers to all these questions can be obtained through VPIQ. Don't delay, sign up today. Contact our EDI Help desk at (717) 735-9429.

Bulletin Board System (BBS)

The Bulletin Board System is a dynamic system allowing us the ability to provide you with various forms of information and interactive inquiries. The BBS has

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many different functions which will give you the ability to view:

- OCNA number listings
- Newsletters
- Fee Schedules
- Accelerate updates
- Additional Documentation Form
- Seminar Registration Form
- Supplier Notices and Alerts
- Medical Policy (this can also be downloaded)

The bulletin board also has a message system which will allow you to direct questions to selected departments within the DMERC. These departments are:

- Professional Relations - Ask your Ombudsman
- Accounting / Medicare Secondary Payer (MSP)
- EDI - Ask the E team
- Returned / Pick up equipment
- General messages which do not apply to specific departments

Medicare Web-Site (www.medicare-link.com)

Do you surf the net? If so, check out our web site. It contains:

- General information, such as Supplier Notices and Alerts
- Customer service frequently asked questions
- EDI information
- Medical Policy
- Newsletters
- Supplier Manual revisions
- General beneficiary information
- CMN information

Medicare E-Mail address (dmerca@ix.netcom.com)

You can communicate directly with us via e-mail at: dmerca@ix.netcom.com.

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HCFA Sets Up a Vaccination Program Against the Millennium Bug

Everyone Who Hasn't Been Marooned on a Desert Island Must Have Heard of the Millennium Bug by Now!

Many computer systems in the public and private sectors will be affected by the Year 2000 Millennium (Y2K) bug if no action is taken in a necessary debugging procedure.

For many years, computer systems have carried two-position date fields. Unless modified, the fields will assume the year 2000 is 1900. This misinterpretation will cause systems to shutdown, result in calculation errors or place at risk the inter-action with other data systems.

Year 2000 bugs have already run amok in a few data systems as discussed in recent newspaper articles. A commonly reported error is that some credit card processing systems cannot accept credit cards with expiration dates of 2000 or later. Such systems reject the "00" as being invalid, thereby causing a major problem for both businesses and their customers. A similar error may already have occurred in some health care providers' offices data systems when patients attempted to pay their bills with credit cards having expiration dates of 2000 and beyond.

In essence, health care providers have many chances of becoming bedeviled by Y2K bugs not only in the credit card processing system but in their other systems such as automated payroll, billing, appointment, and patient records. This same Y2K problem also applies to many diagnostic and treatment machines that have an internal clock built in their computer chips or software, including personal computers.

To avoid the Y2K bug, computer users should contact the vendor who provided the software, hardware, or medical equipment, to make sure that it is certified to continue working properly in the year 2000.

The Y2K bug is not only an operational nuisance but a legal liability issue as well. Many attorneys believe that unless a business (health care provider) takes "reasonable and prudent" measures to avoid Y2K bugs, they could be liable for any harm or damage that their customers (patients) and suppliers may incur.

While the systems in your health care organization may be bug-free, the cashflow operation can still be disrupted if the managed care and fee-for-service payers have bugs in their systems that prevent claims from being received, processed, or paid.

In conjunction with Medicare carriers and intermediaries, the Health Care Financing Administration (HCFA) is working diligently to make sure that Medicare's computer systems and networks will be Y2K bug-free. For example, HCFA has a program to systematically assess, renovate and test each mission critical system in all its facilities, as well as those of each carrier and intermediary by December 31, 1998.

This target will have given HCFA a full year to fix any problems that might have escaped detection during renovation and testing. In addition, Medicare carriers and intermediaries will test their electronic data inter-changes with the hospital information system, billing system, and billing service. This testing ensures that these systems interface and work properly with no interruption in claims and payments processing after the clock ticks at midnight on January 1, 2000.

From President Clinton to Donna E. Shalala to Nancy-Ann DeParle, there is support and urgency for the Y2K project. "At HCFA, everyone has a commitment to ensure that Medicare customers will not encounter payment disruptions caused by a bug in our systems," Gary Christoph, HCFA's Chief Information Officer recently said.

In addition to vendors, the Internet is a good place to look for more information about Y2K problems. The following Web sites contain useful information:

http:\ \ www.year2000.com
(general technical and legal information)

http:\ \www.FDA.gov/cdrh/yr2000/yr2000.html
(medical equipment)

http:\ \www.HCFA. gov
(Medicare).

Dr. Gary G. Christoph who is HCFA's Chief Information Officer and Director of the Office of Information Services contributed this article.

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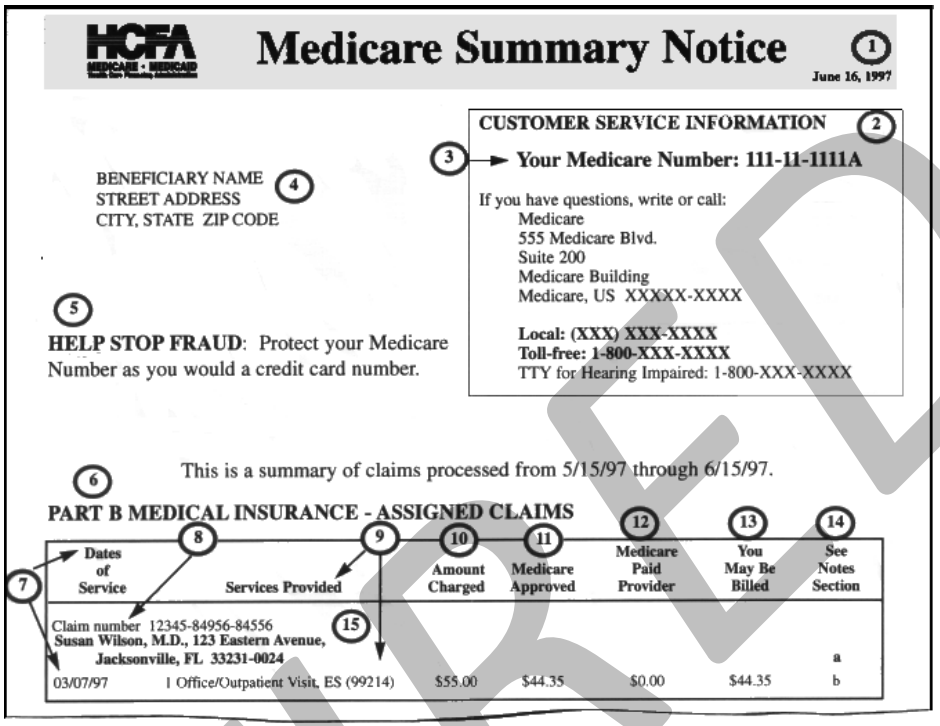
New Beneficiary Medicare Summary Notice

The Explanation of Medicare Benefits (EOMB) notice for beneficiaries has been replaced by a newly designed Medicare Summary Notice (MSN). Effective October 1, 1998, the MSN will be implemented by the Durable Medical Equipment Regional Carriers (DMERCs).



HCFA MEDICARE • MEDICAID

Medicare Summary Notice (1) June 16, 1997

CUSTOMER SERVICE INFORMATION (2)

(3) **Your Medicare Number: 111-11-1111A**

If you have questions, write or call:
Medicare
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Local: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

BENEFICIARY NAME (4)
STREET ADDRESS
CITY, STATE ZIP CODE

(5) **HELP STOP FRAUD**: Protect your Medicare Number as you would a credit card number.

(6) This is a summary of claims processed from 5/15/97 through 6/15/97.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

(7) Dates of Service	(8) Services Provided	(9) Amount Charged	(10) Medicare Approved	(11) Medicare Paid Provider	(12) You May Be Billed	(13) See Notes Section (14)
Claim number 12345-84956-84556 (15) Susan Wilson, M.D., 123 Eastern Avenue, Jacksonville, FL 33231-0024						a
03/07/97	1 Office/Outpatient Visit, ES (99214)	$55.00	$44.35	$0.00	$44.35	b

1 The **Date** the MSN was sent.

2 Refer to the **Customer Service Information** box if you have questions about your MSN. For all inquiries, include your Medicare number, the date of the notice, and the specific date of service you have questions about.

3 **Your Medicare Number** should match the number on your Medicare card.

4 If your **Name and Address** are incorrect on your MSN, please contact both the Medicare carrier shown on your MSN and the Social Security Administration immediately.

5 Read the **Help Stop Fraud** message for information on ways to protect yourself and Medicare against fraud and abuse.

6 **Part B Medical Insurance - Assigned Claims/ Unassigned Claims.** See the back of your MSN for an explanation of Medicare assignment.

7 **Dates of Service** shows when your doctor or supplier provided the service(s) listed. You may use these dates to compare with the dates shown on your doctor or supplier bill.

8 Each claim is assigned a **Claim Number,** which you may be asked to provide when calling regarding your MSN.

9 **Services Provided** is a brief description of the service or supply, the number of services and the service code.

10 Amount Charged is the charge submitted to Medicare by the provider of service(s).

11 **Medicare Approved** is the amount Medicare approved for the service(s) you received.

12 **Medicare Paid Provider.** In most situations, Medicare pays 80 percent of the approved amount after subtracting any unmet portion of the annual deductible. For unassigned service(s), this column is titled Medicare Paid You.

13 **You May Be Billed**. This is the total amount the provider is allowed to bill you. It combines the deductible, the coinsurance and any non-covered charges. If you have supplemental insurance, it may pay all or part of this amount.

14 **See Notes Section**. If a letter appears in this column, refer to the Notes Section. Please see item 16 in this pamphlet.

15 **Provider's Name and Address.** More than one name may be shown. If you were treated by a clinic or group medical practice, the clinic or group name will be shown, followed by the name of the doctor who performed the service. If the service was ordered or referred by another doctor, the referring doctor's name may also be listed. The address shown is the billing address which may be different from where you received the service(s).

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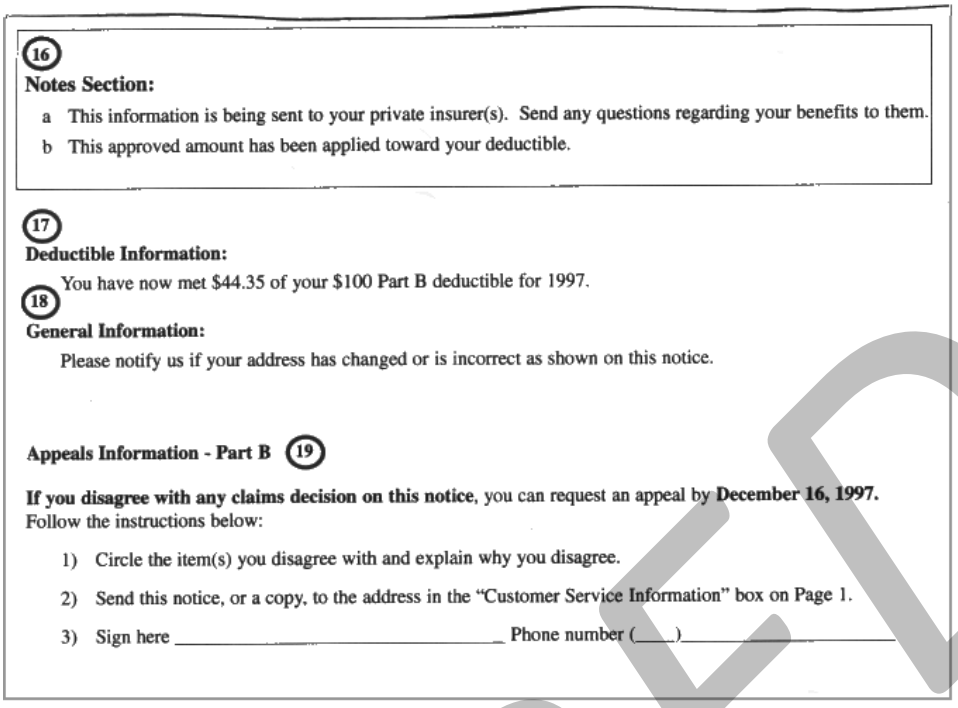

(16)
Notes Section:

a This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.

b This approved amount has been applied toward your deductible.

(17)
Deductible Information:

You have now met $44.35 of your $100 Part B deductible for 1997.

(18)
General Information:

Please notify us if your address has changed or is incorrect as shown on this notice.

Appeals Information - Part B (19)

If you disagree with any claims decision on this notice, you can request an appeal by **December 16, 1997.**
Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.

3) Sign here _____ Phone number (____)_____

16 The **Notes Section** gives more detailed information about your claim.

17 The **Deductible Information** section shows how much of your annual deductible has been met.

18 The **General Information** section provides important Medicare news and information.

19 **Appeals Information**, such as how and when to request an appeal, is shown here. See the back of your MSN for more information and how to get help with appeal requests.

HCPCS

K0456 - Descriptor Change

Effective for dates of service on or after October 1, 1998, the descriptor for code K0456 has been revised to read:

K0456 - Hospital Bed, Heavy Duty, Extra Wide, with any type of side rails, with mattress

Coverage criteria and documentation requirements remain the same as those published in the June 1998 edition of *DMERC Medicare News.*

All numeric procedure codes and modifiers in this newsletter are from the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition, copyright 1997.

Elimination of Accelerate 5.25" Diskettes

Beginning January 1, 1999, the Region A DMERC will no longer provide or support our Accelerate software on 5.25" diskette. If you wish to receive any updates to the software after this date you will need a 3.5" disk drive.

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Medical Policy

Carrier Updating of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

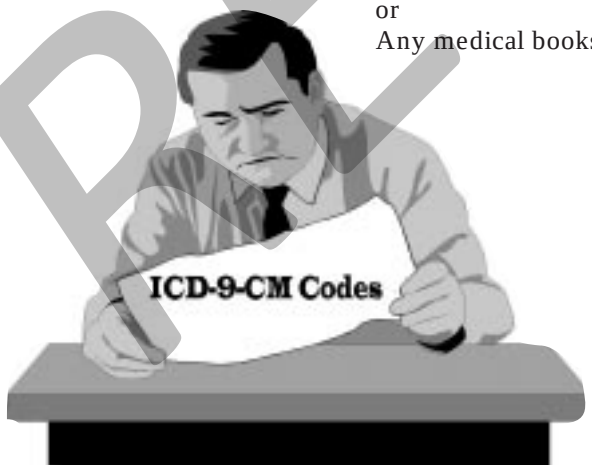
Beginning October 1, 1998, providers may begin using the updated ICD-9-CM codes for claims submitted on or after October 1, and that the updated diagnostic codes must be used for professional services billed on or after January 1, 1999.

The DMERC is required to accept both old and new ICD-9-CM codes for claims received October 1 through December 31, 1998. This grace period gives providers sufficient time to obtain and integrate the latest version of the ICD-9-CM codes into their billing system. It is important for providers to use the most recent version of the ICD-9-CM coding book and to code to the highest level of specificity.

ICD-9-CM books can be obtained from:

American Medical Association	1-800-621-8335
Channel Publishing	1-800-248-2882
Medicode	1-800-999-4600
PMIC	1-800-MED-SHOP

or
Any medical bookstore.



Pricing

Retraction of Inherent Reasonableness

The inherent reasonableness notice for code E0185, published in Region A DMERC's March, 1998 newsletter, has been retracted. Any comments received will be disregarded.

Initial Notice of Inherent Reasonableness

The Region A DMERC has reviewed the 1998 allowables for A4253, A4259, A4311, A4314, A4338, B4150, K0505, and V2020 and determined that they are excessive. Region A has provided, for your review, information reflecting our proposed changes.

The law, under section 1842(b)(8)(A) of the Social Security Act, allows the application of inherent reasonableness to payment amounts for Medicare Part B items and services, other than physician services, that are determined to be either grossly excessive or grossly deficient, allowing carriers to establish realistic and equitable payment amounts.

The revised payment amounts were derived using retail data gathered from telephone inquiries and on-site visits to retailers across the country. Region A obtained retail prices for six of the eight codes mentioned above from four states in each DMERC region. Thus, the four DMERCs obtained prices from a total of 16 states across the country. The states selected in each region consisted of both large and rural states. A number of observations were made for each state, in both urban and rural areas, and included large and small businesses. At least 200 observations were made for each of the six codes. The other two items (A4311 and A4314) represent urological kits that include indwelling, foley, two-way, latex catheter (A4338). Region A is therefore proposing

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that the allowances for these two kit codes be adjusted by the same monetary reduction applied to A4338, since it is included in both of these kits.

Region A believes that 200 observations across 16 states represent a sufficient number of retail pricing observations upon which to base a conclusion regarding retail prices compared with Medicare's current payment amounts. Region A also believes that it would be grossly unreasonable for Medicare to pay higher than the prices that can be obtained from retail businesses. A retail price is the maximum amount charged by a business and, thus, serves as an effective ceiling for what a prudent purchaser would ever expect to pay for an item. This is especially true of a large volume purchaser such as Medicare. Region A selected the median retail price for each item because a median is a reasonable indicator of a fair and equitable payment amount. At least one half of the survey prices are at or below the median amounts. Region A would assume a prudent purchaser could, thus, purchase these products at or below the median price.

For your convenience, the survey data is available under the "general" section of the provider information on Region A's web site at the following address. This data identifies the sources used to calculate the proposed payment allowances based on the median of all sources obtained via phone calls and on-site surveys of retail businesses.

www.medicare-link.com

The revised fees will be imposed 30 days after publication of the Final Inherent Reasonableness Notice. With the exception of code K0505, the limits are to be updated on an annual basis by the normal covered item updates that apply to these items. For K0505, the limit will be updated on an annual basis by the covered item update for durable medical equipment. The annual covered item update factors are as follows:

	1999	2000	2001	2002
DME/Other	0%	0%	0%	0%

Comments regarding these proposed changes may be made during the 60-day comment period ending November 30, 1998. Comments received after this date will not be considered. 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 current retail prices. Please send all comments in writing to:

United HealthCare
Pricing Unit / Inherent Reasonableness
60 East Main Street
Nanticoke, PA 18634

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The proposed limitations to existing fees listed below are based in the median of our national survey data obtained via phone calls and on-site surveys of retail businesses nationwide. Under the Balanced Budget Act (BBA) of 1997, reductions or increases to Medicare allowances cannot exceed 15 percent annually. Listed below are the proposed limitations derived from our national surveys, the current Medicare allowances, the percent of difference reflected between the existing fees and our proposed limitations, and the limit to be effective 30 days after the date of final notice.

With the exception of code K0505, the limits are to be updated on an annual basis by the normal covered item updates that apply to those items. For K0505, the limit will be updated on an annual basis by the covered item update for durable medical equipment. Any fees reflecting a difference greater than 15 percent will be reduced each subsequent year until the full reduction is imposed. Territories for the purpose of this initial review will be finalized at a later date.

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		CT	DE	MA	ME	NH	NJ	NY	PA	RI	VT
A4253	**Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips**										
	1	$35.49		$35.49	$35.49	$35.49	$35.49	$35.49	$35.49		$35.49
	2	$36.73	$34.20	$36.73	$36.73	$36.73	$36.73	$36.73	$36.73	$34.21	$36.73
	3	3.38%		3.38%	3.38%	3.38%	3.38%	3.38%	3.38%		3.38%
	4	$35.49	no change	$35.49	$35.49	$35.49	$35.49	$35.49	$35.49	no change	$35.49
	The proposed allowances for A4253 are based on limitations established using the median of our national survey retail pricing data.										
A4259	**Lancets, per box of 100**										
	1	$7.81	$7.81	$7.81	$7.81	$7.81	$7.81	$7.81	$7.81	$7.81	$7.81
	2	$12.15	$10.33	$10.33	$10.33	$10.33	$12.15	$12.15	$10.33	$10.33	$10.33
	3	35.72%	24.40%	24.40%	24.40%	24.40%	35.72%	35.72%	24.40%	24.40%	24.40%
	4	$10.33	$8.78	$8.78	$8.78	$8.78	$10.33	$10.33	$8.78	$8.78	$8.78
	The proposed allowances for A4259 are based on limitations established using the median of our national survey retail pricing data.										
A4311	**Insertion tray w/o drainage bag w/indwelling catherter, foley type, 2-way latex w/coating**										
	1	$10.89	$10.85	$10.52	$10.52	$9.88	$10.85	$11.84	$10.85	$9.83	$10.37
	2	$13.26	$12.04	$13.33	$13.33	$12.69	$12.04	$12.90	$12.04	$12.04	$13.18
	3	17.87%	9.88%	21.08%	21.08%	22.14%	9.88%	8.22%	9.88%	18.36%	21.32%
	4	$11.27	$10.85	$11.33	$11.33	$10.79	$10.85	$11.84	$10.85	$10.23	$11.20
	The proposed allowances for A4311 are based on the same monetary reductions applied to code A4338.										
A4314	**Insertion tray w/drainage bag w/indwelling catheter, foley type, 2-way latex w/coating**										
	1	$21.75	$21.71	$17.69	$17.69	$17.69	$21.71	$22.21	$21.71	$18.29	$17.69
	2	$24.12	$22.90	$20.50	$20.50	$20.50	$22.90	$23.27	$22.90	$20.50	$20.50
	3	9.83%	5.20%	13.71%	13.71%	13.71%	5.20%	4.56%	5.20%	10.78%	13.71%
	4	$21.75	$21.71	$17.69	$17.69	$17.69	$21.71	$22.21	$21.71	$18.29	$17.69
	The proposed allowances for A4314 are based on the same monetary reductions applied to code A4338.										
A4338	**Indwelling catheter; foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each**										
	1	$8.89	$8.89	$8.89	$8.89	$8.89	$8.89	$8.89	$8.89	$8.89	$8.89
	2	$11.26	$10.08	$11.70	$11.70	$11.70	$10.08	$9.95	$10.08	$11.10	$11.70
	3	21.05%	11.81%	24.02%	24.02%	24.02%	11.81%	10.65%	11.81%	19.91%	24.02%
	4	$9.57	$8.89	$9.95	$9.95	$9.95	$8.89	$8.89	$8.89	$9.44	$9.95
	The proposed allowances for A4338 are based on limitations established using the median of our national survey retail pricing data.										

	CT	DE	MA	ME	NH	NJ	NY	PA	RI	VT
V2020	**Frames, purchase**									
1	$49.00		$49.00	$49.00	$49.00				$49.00	$49.00
2	$52.61	$46.55	$52.61	$52.61	$52.61	$46.55	$46.55	$46.55	$52.61	$52.61
3	6.86%		6.86%	6.86%	6.86%				6.86%	6.86%
4	$49.00	no change	$49.00	$49.00	$49.00	no change	no change	no change	$49.00	$49.00

The proposed allowances for V2020 are based on limitations established using the median of our national survey retail pricing.

The proposed allowable for the following code would replace the current controlling allowable, applicable to all states. Please note that the proposed allowance may not reflect suppliers' actual allowances. Medicare calculates the allowance for this code by selecting the lower of the prevailing charge, lowest charge level prevailing, suppliers' customary charge, inflation index charge and actual charge. The proposed allowance will replace the current prevailing charge. Your reimbursement will be the lower of the proposed allowance, the lowest charge level prevailing, your suppliers' customary charge and actual charge.

B4150 **Enteral formulae; Category I; semi-synthetic intact protein/protein isolates, 100 calories = 1 unit**

1 $0.51

2 $0.61

3 16.39%

4 $0.52

The proposed allowance for B4150 is based on limitations established using the median of our national survey retail pricing data.

The following code's current allowable is based on 95% of the national average wholesale price of the drug. If a drug has multiple sources, 95% of the median of average national wholesale generic and comparable priced brand name prices are used. The proposed allowable would replace the current allowable for all states.

K0505 **Albuterol, inhalation solution administered through DME, unit dose form, per mg**

1 $0.42

2 $0.47

3 10.64%

4 $0.42

1 - Proposed allowable.

2 - Current allowable.

3 - Percent of difference (current allowable compared to proposed limitation).

4 - 1999 Proposed fee.

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Elimination of Funding EMC Toll-Free Lines for Participating Physicians and Suppliers

As part of incentives to increase participation, the Health Care Financing Administration (HCFA) made available toll-free lines to providers for electronic media claims (EMC) transmission. Unfortunately, because of budget constraints, HCFA can no longer continue this incentive. Effective January 1, 1999, we can no longer provide EMC toll-free telephone service to participating physicians and suppliers. As your Medicare carrier, it is extremely important for us to assist you during this transition in order to avoid any interruption in your submission of electronic claims. It is our goal to help you obtain quality, affordable long distance telephone service. While the decision on which company to select is yours, there are a variety of charge features from which to choose. Please be aware that we cannot pay any long distance service to deliver your electronic claims submissions to us. As your Medicare carrier, we must also remind you that, at this time, we cannot accept electronic claims via the Internet as this would risk the privacy of Medicare beneficiary data. However, HCFA is exploring the Internet option.

Billing

Billing for Vision Services

The Region A DMERC has been dealing with an excessive number of beneficiaries that seem to be questioning their responsibility to pay for certain vision services. For this reason, Region A is alerting the supplier community of the need to submit accurate and complete claims for all services, whether they are covered or non-covered. This will serve as a very clear indication to the beneficiary that the DMERC considers a service as **Covered** or **Non-Covered** with a denial but might allow them to submit to a secondary insurer for coverage of that Medicare denied service.

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians or suppliers from imposing a charge for completing and submitting a claim. Payment for assigned services not filed within 1 year (for services on or after 9/1/90) are reduced 10 percent. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. HCFA is responsible for assessing sanctions and monetary penalties for non compliance.

Region A is requesting that suppliers submit claims in the following manner:

Submit on the 1500-Claim form all services that were rendered, not just those services that are covered.

Examples of the above might include, but are not limited to:

- When provided, bill for deluxe frame (V2025) as well as the standard frame (V2020).
- When provided, bill for refractive lenses even though the diagnosis code will deny as non-covered.
- Billing for tints, anti-refractive coatings, UV lenses or oversized lenses when provided as a preference item, even though medical necessity does not exist, so that the beneficiary can see that they were denied. If medical necessity does exist for these, use the ZX modifier.
- When provided, bill for scratch resistant coating (V2760) and progressive lenses (V2781), even though they will deny as non-covered.

EDI

Addendum Required

Effective July 6, 1998, the Region A DMERC began requiring a signed addendum from all submitters who wish to receive claim status inquiry, electronic remittance notices, and eligibility. You may request copies of all addenda from the EDI Help Desk or download copies from our web page.

New Claim Status Inquiry System

With our conversion to the new VMS system, Region A is converting to a new claim status inquiry system, also known as VPIQ. This system offers more than the previous claim status system. With VPIQ, you will be able to search for a HICN or date of service for your provider number, and you can receive complete listings of pending claims, as well as a summary of the number of claims pending in the processing system. If you are a "Participating Provider," the VPIQ system offers electronic eligibility online. To be setup for VPIQ, contact the EDI Help Desk at 717-735-9429 to receive an addendum for you to authorize the setup of these options.

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Professional Relations

June Seminar Update

The Professional Relations department at the Region A DMERC has recently completed the June Seminars. Region A would like to thank all of the suppliers that were able to attend and for their participation. The seminars are a way of meeting suppliers that may require our assistance in the future.

The following is a list of comments from the evaluations that were completed at the seminars, along with the overall rating of the seminars. Region A looks forward to conducting the Fall educational workshops, scheduled for October 1998. (Please refer to the June 1998 edition of the *DMERC Medicare News* for details and registration information.)

Hartford, CT

- Speakers gave detailed answers
- Informative
- Presenters knowledgeable
- Seminar moved quickly - very direct
- Should have separate seminar for new suppliers
- Answered even the smallest questions
- Better handouts, visuals, presenters than last time
- Please next time have seminar in more central location.

Boston, MA

- Excellent presenters
- Informative
- Too many "personal" issues - don't pertain to everyone
- Presenters very familiar with their specific areas
- Did not get a lot of information

Portland, ME

- Seminar very informative
- Some area's of the handouts were too dark to read
- Manual needs improvement. Include visual information in manual

East Windsor, NJ

- "I feel a great deal more comfortable than I did when I came to the workshop"
- Very informative and enlightening
- Excellent organization of materials

Albany, NY

- Excellent visuals
- Speakers knowledgeable and accessible
- Very helpful
- Very informative of VIPS
- Presenter should repeat questions so audience can hear
- "Presenters were lively - necessary when material is not exactly spell binding"
- Limit the number of questions related to an issue.
- Handouts could be more legible. Would like something closer to our area. Presenters need to listen to questions better.
- Should spend more time on specific billing utilization and medical necessity problems. We can all read the handouts ourselves - they are very clear and detailed.

Buffalo, NY

- Good idea having microphone in audience - we could hear everyone's questions
- Presenters very thorough
- A great experience

East Elmhurst, NY

- Seminar could be more in depth
- Discuss in more detail medical policy

Philadelphia, PA

- "Keep audience in line! - cut them off when asking questions"
- Session should be day long
- Excellent as always
- Presenters knowledgeable
- Wish the seminars were held more frequently
- "Learned a new system which will make my job a lot easier"
- Handouts excellent
- Slides copied into book form - good idea
- Too much time is devoted to questions that only pertain to certain providers. All questions should be reserved until the end of the session - leaving other suppliers the option to stay or leave.
- Stick to the agenda please

Pittsburgh, PA

- Speakers held my attention
- Learned a lot
- Knowledgeable speakers
- Liked seminar booklet - very easy to read

Wilkes-Barre, PA

- Could have stressed more issues on Fraud and Abuse

Two thousand and four suppliers attended the June seminars, 676 of those suppliers completed evaluation forms and rated them as follows:

- 32.18% felt Region A improved
- 62.99% felt Region A stayed the same
- 4.83 % felt the seminars were worse than previous

RETIRED

Important Announcement from Professional Relations

Supplier Notice 98-08
May 29, 1998

Effective June 1, 1998, Amy Capece - Pharmacy / Nutrition - PA - Ombudsman and Michele Healey - Respiratory - New England (NH, ME, RI, VT) - Ombudsman, have accepted Technical Service Coordinator positions within the DMERC.

Kevin Quaglia will assume the responsibilities of Ombudsman for the New England States (NH, ME, RI, VT); as well as the Respiratory category in the Product / Process Focus Group (P / PFG). Kevin has been with the DMERC for four years serving the Claim Entry and Customer Service Units, the last two years as a Professional Relations Support Representative.

Kevin can be reached at 717-735-9666 (from the main menu selection 3 for Ombudsman, then selection 1 for the Respiratory Category).

Marc Rosario will assume the responsibilities of Ombudsman for the state of Pennsylvania; as well as the Pharmacy / Nutrition category in the Product / Process Focus Group (P / PFG). Marc has been with the DMERC for four years as a Customer Service Representative on the Provider help desk, the last three years as a Service Coordinator in the Customer Service Unit.

Marc can be reached at 717-735-9666 (from the main menu selection 3 for Ombudsman, then selection 3 for the Pharmacy / Nutrition Category).

Please join us in wishing Amy, Michele, Kevin and Marc success in their new assignments.

Home Blood Glucose Monitors

Supplier Notice 98-09
July 6, 1998

What appears below is in addition to the DMERC Regional Medical Review Policy (RMRP) on home blood glucose monitors and their associated supplies and accessories for insulin-treated diabetics.

Effective for dates of services on or after July 1, 1998, Medicare coverage for glucose monitors and related accessories and supplies is being expanded to include patients who are not being treated with insulin injections. (Prior to this date, Medicare only covered these items for patients who were being treated with insulin injections.)

The patient must meet at least the following basic criteria:

1. The patient has diabetes (ICD-9 codes 250.00-250.93) which is being treated by a physician; and
2. The glucose monitor and related accessories and supplies have been ordered by the physician who is treating the patient's diabetes; and
3. The device is designed for home use.

The physician treating the beneficiary's diabetes must state on the prescription to the supplier, the diagnosis (ICD-9-CM or narrative) of diabetes, whether or not the beneficiary is being treated with insulin injections, the item / supplies / accessories needed, the quantity to be dispensed, and the frequency with which the beneficiary should use them. A prescription which merely states, "as needed," will not be considered valid for Medicare.

This prescription will be valid for 6 months, at which time the physician will have to renew it in order for the beneficiary to continue to receive covered test strips and lancets. Renewal of the prescription must be initiated by either the treating physician, the beneficiary, or the beneficiary's caregiver. A supplier may not initiate an order for these items. Initiation of the renewal should be dependent upon the beneficiary's use of these supplies, and the renewal prescription must contain the same information as described above for initial prescriptions.

DMERCs will only pay for glucose monitoring supplies that are medically necessary. Medical necessity requires that the beneficiary be under the care of a physician and the frequency of testing be determined by the physician treating the beneficiary's diabetes.

Quantities of home glucose monitor supplies that are not prescribed according to the above criteria will be denied as not medically necessary.

Documentation Requirements

The supplier must have an original order which is signed and dated by the physician who is treating the beneficiary's diabetes. For supplies, the order must list the items that are to be dispensed and the frequency of testing. A narrative diagnosis and / or ICD-9-CM diagnosis code must be present on each order for a glucose monitor or related accessory or supply. The order must also include a statement indicating whether or not the patient is being treated with insulin injections. The supplier must obtain a new written order from the treating physician every 6 months.

An ICD-9-CM diagnosis code describing the condition which necessitates glucose testing must be included on each claim for the monitor, accessories, and supplies. The supplier should continue to use the ZX modifier for insulin-treated diabetics, as described in the current DMERC RMRP for home blood glucose monitors.

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Attention: All Electronic Submitters

Supplier Notice 98-10
July 10, 1998

Would you like to save time and money on phone calls to provider services?

Would you like to make claim status checks easier?

Then sign-up for the NEW VIPS Provider Inquiry System, known as VPIQ.

This system offers:

- Summaries & listings of pending claims
- The ability to check claims by HICN & Date of Services
- The ability to check paid or denied claims
- The ability to do a Beneficiary Alpha Inquiry
- The ability to check on completed claims waiting to be released for payment
- The ability to check the estimated mail or EFT date of pending payments

If you are a "PARTICIPATING" supplier you can also check Beneficiary Eligibility on-line with the VPIQ system!

Available Information includes:

- Entitlement / termination dates
- Deductibles met for the current year
- HMO Data
  - HMO Name
  - HMO Zip Code
  - HMO Code (cost or risk)
  - HMO Entitlement / termination dates
- Medicare Secondary Payor - indication whether there has been any activity in the past year

Team EDI encourages you to utilize this low-cost system. It contains valuable information that will be available to you at your fingertips, and can be utilized from approximately 6 am to 9 pm, Monday through Friday.

To sign-up for this exciting new system contact the EDI Help desk at 717-735-9429.

Change in EDI Front End Edits

Supplier Notice 98-11
July 13, 1998

As of August 1, 1998 the Region A DMERC will begin rejecting claims on our EDI front end edits for records GU0 59 through 71 if they contain blanks or spaces; they must contain a numeric value. Please refer to your NSF 3.01 Matrix for valid values. If you have any questions please contact the EDI Help Desk at 717-735-9429.

Attn. Diskette Submitters

Supplier Notice 98-12
July 24, 1998

Region A DMERC has evaluated the cost effectiveness of accepting diskette submissions of claims for EDI. Effective ***October 1,1998*** the Region A DMERC will no longer accept any claims submitted on diskette.

Options to submit your claims are:

- Vendor software
- Billing Service
- Clearinghouse or
- Region A's low cost software

Any questions should be directed to TEAM EDI at 717-735-9429.

Revision to Supplier Notice 98 -11 Change in EDI Front End Edits

Supplier Notice 98 -13
July 31, 1998

Please note: The August 1, 1998 date has been changed to September 13, 1998.

As of **September 13, 1998** the Region A DMERC will begin rejecting claims on our EDI front end edits for records GU0 59 through 71 if they contain blanks or spaces; they must contain a numeric value. Please refer to your NSF 3.01 Matrix for valid values. If you have any questions please contact the EDI Help Desk at 717-735-9429.

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EDI CMN Reject Report

Supplier Notice 98 -14
August 6, 1998

Effective immediately team EDI will begin mailing CMN Reject Reports to all submitters that have submitted CMNs that meet one or more of the following criteria:

The CMN Reject Report is sent to all EDI submitters when CMNs associated with **accepted** EDI claims are rejected by the VMS system. If the EDI CMN meets one of the five conditions listed below, the claim will be accepted into the system and processed using the certification information already on file, however, the CMN filed with the claims will not be accepted into the system.

Reject Code	Definition
3030	Initial Date Dup - we already have an initial certification for this procedure code with the same dates.
3031	Initial Date Previous End Date - already have an initial certification for this procedure and the initial date of the certification just submitted is less than the end date of the previous initial certification.
3032	Current Recert/Revision Date < previous - this could mean one of two things: • This certification is a duplicate of a previous revision/recertification sent in on a previous claim. • The recertification date on the latest CMN is earlier than the revision/recertification date on the previous claim.
3047	Recertification Initial Date invalid - the initial date on the incoming EMC recertification is not equal to the Initial Date on the CMNs already on file.
3048	Cannot recertify discontinued CMNs - the EMC submitter tried to recertify a CMN that has been placed into a discontinued status within out system. This report will also show the corrected HIC numbers when the submitted HIC number was not correct.

Important Announcement

Supplier Notice 98-15
August 26, 1998

Doris Spencer - Orthotics and Prosthetics - CT, MA Ombudsman, has accepted a position within the DMERC Program Integrity Unit, effective October 1, 1998.

David N. Fiorini will replace Doris Spencer as Ombudsman, assuming the same territory and product/process focus group category. David has been with the DMERC for four and a half years having served the Program Integrity and Customer Service Units. For the last three and a half years David has served as the DMERC Congressional Relations Representative.

Beginning October 1, 1998, David can be reached at 717-735-9666 (from the main menu selection 3 for Ombudsman, then selection 2 for the Orthotics and Prosthetics Category).

Please join us in wishing Doris and David success in their new assignments.

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HCPCS Modifiers

Supplier Notice 98-16
September 1, 1998

Valid HCPCs modifiers must be billed with the correct HCPCs procedure codes when submitted to the Region A DMERC to properly represent the equipment or supply that was delivered.

Claims with missing or invalid modifiers will be denied as unprocessable in accordance with HCFA return / reject mandate. This will affect all claims received on or after October 1, 1998.

In addition claims will be denied under the return / reject mandate when unnecessary modifiers are used.

Claims that are denied under the return / reject mandate must be resubmitted with complete valid information for appropriate claim adjudication.

Please refer to the fee schedule in your *Supplier Manual* for a complete listing of HCPCs procedure codes and associated HCPCs modifiers.

Durable medical equipment and supplies that are classified as inexpensively and routinely purchased DME must always be billed with an NU modifier when purchased new; a UE modifier when purchased used; or an RR modifier when rented.

DME that is classified as a capped rental must always be billed with an RR or NU modifier; a KH, KI, KJ modifier and a BU, BR, or BP modifier when applicable.

Please reference the HCPCs modifier section in your *Supplier Manual.*

Certain medical policies incorporate modifiers to use to indicate when medical coverage is met. Please refer to specific policy documentation requirements as outlined in your *Supplier Manual*, for proper usage of medical policy specific modifiers.

Below are some examples that depict the correct HCPCs modifiers to be used with the corresponding HCPCs codes.

Examples:	Correct	Incorrect
1. An electric wheelchair when the beneficiary has chosen the purchase option in the first month.	K0011 NUKHBP	K0011 NUBP
2. A capped rental item billed as a rental for the first month	E0260 RRKH	E0260 RR
3. A capped rental item billed as a rental in the first month with a waiver of liability.	E0260 RRKHGA	E0260 RRGA
4. A wheelchair accessory that is being added to a wheelchair more than 3 months after the initial issue of the wheelchair and the accessory is billed as a purchase.	K0021 NUKA	K0021 KA
5. A cane purchased new would be billed:	E0100 NU	E0100
6. Blood glucose strips for insulin dependents	A4253 ZX	A4253 NUZX
7. Humidifier, used with CPAP device, purchase	K0268 NU	K0268
8. Urological supplies meeting policy coverage criteria	A4314 ZX	A4314 ZXNU
9. Enteral Formulae	B4150	B4150 NU
10. Capped rental wheelchair billed for maintenance and service	K0001 MS	K0001 MSRR
11. Wheelchair accessory billed as a replacement	K0031 NURP	K0031 NU or K0031 RP
12. Bifocal lens for left eye	V2203 LT	V2203 NULT

For additional information on the HCFA return / reject mandate, reference the December 1995 and the March 1996 issues of the *DME Medicare News.*

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DMERC Medicare News

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