DMERC
Medicare
News

DMERC Region A Service Office • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800 • Phone (570) 735-9445 • www.medicare-link.com
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Notification of Millennium Rollover Year-End Claims Processing

Our goal for the year 2000 rollover is to ensure a smooth and risk free transition to the new millennium. To accomplish it, there are certain steps we must take which are outside of our normal processing routine. We are providing you with this information as early as possible so you may take the necessary action to adjust your processing and cash flow needs. With appropriate preparation, you will not be adversely impacted.

Year-End Claims Processing Schedule

The time frame of December 29, 1999 through 31, 1999 will be used to perform a comprehensive system back-up and to complete finalized month-end, quarter-end, and year-end processing. This will begin at 6:00 P.M. (ST) December 28, 1999 and end at 9:00 A.M. on January 1, 2000. This means that for this period of time, you will not have electronic access to the system to complete any type of claim function (e.g., eligibility verification, claims inquiry). System cycles will also not run and provider payments will not be generated on December 29 and 30, 1999. The first system cycle will be Saturday, January 1, 2000. Provider payments will be mailed and electronic funds transferred on Monday, January 3, 2000 in accordance with the normal payment disbursement schedule. The chart below delineates these activities on a day by day basis.

Date	Claims Processing Impact
Tuesday, December 28, 1999	This is the last day to do any type of claims processing activity. No claims processing activity after 10:00 P.M. System cycles will run as normal. Provider payments disbursed as usual. Electronic providers can submit claims. Electronic Reject Reports will be generated.
Wednesday, December 29, 1999 through Friday, December 31, 1999	No access to the system. No system cycles will run. No provider payments disbursed. Electronic providers can submit claims. Electronic Reject Reports will be generated.

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www.medicare-link.com

HCFA Office
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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins issued after October 1, 1999 are available at no cost from our website at www.medicare-link.com.

Date	Claims Processing Impact
Saturday, January 1, 2000	System available for access. System cycle will run. Electronic providers can submit claims. Electronic Reject Reports will be generated.
Sunday, January 2, 2000	System available for access. Electronic providers can submit claims. Electronic Reject Reports will be generated.
Monday, January 3, 2000	Business as usual. System available for access. System cycle will run. Provider payments disbursed. Electronic providers can submit claims. Electronic Reject Reports will be generated.
Tuesday, January 4, 2000	System available for access. System cycle will not run. Provider payments disbursed. Electronic providers can submit claims. Electronic Reject Reports will be generated.
Wednesday, January 5, 2000 and Beyond	Business as usual. System available for access. System cycle will run. Provider payments disbursed. Electronic providers can submit claims. Electronic Reject Reports will be generated.

Provider Preparation

Providers must prepare for this period. Proper preparation will minimize any impact to your claims processing functions and financial management responsibilities.

All Providers

As with any holiday weekend, providers will experience a short period of time where no Medicare payments will be disbursed on December 31, 1999 through January 2, 2000. Providers should plan accordingly, as advance payments will not be available for this period. In addition (the system unavailability) may impact our ability to respond to provider inquiries during this period.

Electronic and Paper Claim Providers

For both electronic and paper claims, the key to the payment cycle is the date of receipt. Because of this, the holiday weekend should not negatively impact the payment cycle.

- **Electronic Claim Providers**

Electronic providers can access the system until 10:00 p.m. on December 28, 1999 for claims inquiry functions. Electronic providers who submit claims via file transfer can continue to submit claims, however, the claims will not be read into the system until January 1, 2000. The claims will be posted as received by the date they were received at

the carrier and not the date that they were read into the system. For example, if a provider transmits an electronic file to the carrier on December 31, the file will be read into the system on January 1, 2000 but the receipt date posted on the claims will read December 31, 1999.

- **Paper Claim Providers**

  Paper providers may continue to send paper claims to the carrier during this period. However, the carrier will not be able to enter claims into the system. On January 1, 2000, the carrier will begin keying paper claims received on December 29, 1999 and December 30, 1999. The date posted will be the actual date of receipt and not the date the claim was keyed.

Return to Normal Claims Processing Activities

On January 3, 2000, all claims processing activities will return to the normal schedule; however, a payment cycle will not be run on Tuesday, January 4, 2000. The system will be available Monday through Friday from 7:00 A.M. to 10:00 P.M.

Reminder on Claims with Year 2000 Dates of Service

Beginning January 1, 2000, you may file claims as usual, but Medicare contractors will hold all claims with dates of service on or after January 1, 2000 to no later than January 17, 2000 in order to correctly apply the year 2000 payment and other annual updates, including any changes in beneficiary coinsurance and deductibles. You will not need to take any action, other than submitting a millennium compliant claim, to receive the correct payment amount.

By law, electronic clean claims must be held for at least 14 calendar days but no longer than 30 calendar days before payment can be made. The period of time from receipt of year 2000 claims will count toward these requirements. No later than January 17, 2000, all claims for services in the year 2000 will be released for processing, and claims are expected to be finalized for payment very quickly. Therefore, holding claims with year 2000 service dates to no later than January 17, 2000 should only minimally affect their date of payment, if at all (because of the statutory requirement to hold claims payment for at least 14 calendar days).

Claims with Service Dates Prior to Year 2000

Beginning January 1, 2000, claims having dates of service occurring during the calendar year 1999 or a previous year will continue to be processed and paid using the appropriate payment rates. However, because of the way our system functions, any claims received on or after January 1, 2000 that include services occurring during calendar year 2000 will be held in its entirety to no later than January 17, 2000. If you have a claim with dates of service occurring both in 2000 and in a previous year, and you do not wish the entire claim held to no later than January 17, 2000, you should send in two separate claims: one for year 1999 (or earlier) services, and one for year 2000 services. In this way, the processing of your claims for year 1999 (or earlier) services will not be held.

If you have questions about this article, please contact our Provider Services Unit at 570-735-9445.

Reviews

Helpful Hints for Filing Reviews

To ensure that your requests for review of an initial claim determination can be handled promptly and accurately, keep these helpful hints in mind:

- Be specific in your review request. Provide the beneficiary's name, Health Insurance Claim (HIC) number, and the date of service. To identify the specific claim being requested for review, provide the Internal Control Number (ICN) assigned to the initial claim. Additionally, remember to include surgery dates, equipment pick-up and/or delivery dates, specific make and model numbers of equipment, and the purpose or use of certified equipment or supplies where appropriate. For complete instructions refer to Section 8.1, pp. 1-6 of the *Region A DMERC Supplier Manual*.

- When requesting a review of an initial claim determination involving a Certificate of Medical Necessity (CMN), be sure all required fields are completed, i.e.: all questions on the CMN have been answered; the CMN includes the physician's address, as well as the physician's signature; and the date the CMN was signed. Any additional documentation to support the need for equipment and/or supplies should be included with your review request. Also, the supplier's National Supplier Clearinghouse (NSC) number and the Unique Physician Identification Number (UPIN) should be documented on the Certificate of Medical Necessity as well as on the initial claim form. Refer to Section 12.7, pp. 49 - 64 of the *Region A DMERC Supplier Manual*.

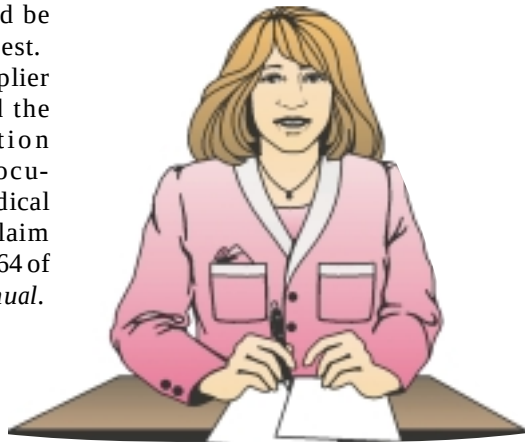
- When including Medicare Remittance Notices or Electronic Remittance Notices as part of your request for review, be sure to highlight or circle the beneficiaries for whom the review is being requested.

- Ensure that all handwritten requests for review are legible.

- When faxing requests for review, ensure that all pages are transmitted successfully. Be sure to use the appropriate fax number, which is 570-735-9599. Please note that there is a six-page fax limit on fax transmissions.

Refer to: Supplier Notice 98-24 "DMERC Communication Suggestions"

- The Region A DMERC had accepted medical necessity denials as adjustments in certain situations. However, these denials must be submitted as reviews in order to be consistent with the appeals process. This process ensures compliance with providing adequate documentation with the review request. Please refer to Supplier Notice 99-36.



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Medical Policy

Medical Policy Revisions

DMERC regional medical review policy (RMRP) revisions for the following policies are included in the accompanying *Region A DMERC Supplier Manual* revision:

- Breast Prosthesis
- Enteral Nutrition
- Respiratory Assist Devices
- Urological Supplies
- Walkers

Among other changes in these policies, it is important to note the following:

- Breast Prosthesis: an ICD-9 diagnosis code will now be required on claims.
- Enteral Nutrition: Addition of a new code (A5200).
- Respiratory Assist Device: Revision of the coverage and payment criteria for Group I, Group II, and Group III patients. In addition, the policy revision incorporates the payment category assignments for the new codes K0532 and K0533.
- Urological Supplies: Addition of a new code (A5200) and revision of the coverage and payment criteria for sterile intermittent catheter use.
- Walkers: Addition of a new code (E0144).

Breast Prosthesis – Policy Revision

A revision of the Breast Prosthesis policy is included in the accompanying Supplier Manual update. The following changes were made:

- A requirement to enter an ICD-9 code on the claim has been added.
- New HCPCS codes from January 1999 and for January 2000 are added.
- Definitions and coverage statements that have been previously published in DMERC bulletins have been added.

The new requirement for ICD-9 codes is effective with dates of service on or after April 1, 2000.

Urological Supplies – Policy Revision

A revision of the Urological Supplies policy is being published in the *Region A DMERC Suppliers Manual* (Chapter 16, section 16.9) accompanying Supplier Manual update. The following changes were made:

- Coverage and payment criteria for intermittent catheterization have been revised.
- A new code, A5200 (percutaneous catheter/tube anchoring device, adhesive skin attachment) has been added.

These changes are effective for dates of service on or after October 1, 1999.

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Respiratory Assist Devices – Policy Revised

Elements of the Respiratory Assist Device policy have been revised as outlined below:

- The PaCO2 Coverage and Payment criterion for "Group II Chronic Obstructive Pulmonary Disease" (COPD) is reduced from ≥55 mm Hg to ≥52 mm Hg.
- Two elements (B and D) of the Coverage and Payment criteria for "Group III Central Sleep Apnea " have also been revised. The revised criteria now read:

  B. The exclusion of obstructive sleep apnea (OSA) as the predominant cause of sleep-associated hypoventilation,

  D. Oxygen saturation ≤88% for at least five continuous minutes, done while breathing the patient's usual FIO2,

- The Respiratory Assist Devices (RAD) DMERC Medical Review Policy contains several provisions to reimburse Code K0533 (Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface) comparable to the least costly medically appropriate alternative Code K0532 (Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface) when various Coverage and Payment Criteria are not met. Since the K0533 is in the "Frequent and Substantial Servicing" payment category and K0532 is in the "Capped Rental" payment category, a least costly medically appropriate alternative payment cannot be made. Consequently, K0533 will be denied as not medically necessary when the policy criteria are not met.

These revisions are effective as of the original effective date of the policy.

Testing and Physician Evaluation for Oxygen Certifications: Review

In an effort to clarify timeliness requirements associated with blood gas testing and physician evaluations for initial certification and recertifications of beneficiaries for the oxygen benefit, the following summary is offered:

Blood Oxygen Testing

Initial Certification

Groups I and II: Must be tested within 30 days prior to the date of initial certification.

Recertifications

Group I: Most recent available blood oxygen result.

Group II: Must be tested between 61st - 90th day after the date of initial certification.

Group I or II: Must be tested within 30 days prior to the date of recertification if the initial certification specified a length of need less than lifetime.

Physician Evaluation

Initial Certification

Groups I and II: Must be seen and evaluated within 30 days prior to the date of initial certification.

Recertifications

Group I and II: Must be seen and re-evaluated within 90 days prior to any recertification date.

The physician evaluation requirements are effective for dates of service on or after April 1, 2000.

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HCPCS

Year 2000 HCPCS Codes

In the past, the HCPCS Codes and descriptors of all new, modified, or discontinued (deleted) HCPCS Codes have been published in the newsletter. However, due to the volume at this time, only the HCPCS Codes are being published in this newsletter. The *Region A DMERC Supplier Manual*, Chapter 5, has been updated to indicate all 1999 and Year 2000 code activity and can be referenced for all HCPCS Code descriptors. This update is included in the accompanying *Region A DMERC Supplier Manual* revision. Please utilize the table in Chapter 5, Section 5.6 to determine the action taken with each HCPCS code (i.e., A = Add, C = Change, D = Discontinue, etc.). The HCPCS Index at the end of the chapter has also been updated for easy reference.

Procedure codes that have been added, changed, or discontinued are listed below and on the following page, and are effective for dates of service on or after January 1, 2000 unless otherwise indicated. **An * (asterisk) indicates these codes are effective for dates of service on or after April 1, 2000.**

New Codes

A4280	A4386	A7007	E0780	J7516*	J7658
A4369	A4387	A7008	E1390	J7517*	J7659
A4370	A4388	A7009	E1900	J7608	J7668
A4371	A4389	A7010	J0200	J7618	J7669
A4372	A4390	A7011	J0456	J7619	J7680
A4373	A4391	A7012	J1327	J7628	J7681
A4374	A4392	A7013	J1438	J7629	J7682
A4375	A4393	A7014	J1450	J7631	J7683
A4376	A4394	A7015	J1745	J7635	J7684
A4377	A4395	A7016	J1750	J7636	J8510
A4378	A5508	A7017	J2352	J7367	J8520
A4379	A7000	A9900	J2500	J7638	J8521
A4380	A7001	A9901	J2543	J7639	J9001
A4381	A7002	E0144	J2780	J7642	J9355
A4382	A7003	E0590	J3245	J7643	J9357
A4383	A7004	E0602	J7198	J7644	L3807
A4384	A7005	E0616	J7199	J7648	L9900
A4385	A7006	E0779	J7515*	J7649	Q0187

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Modified Codes (Descriptor Changes)

The EJ Modifier descriptor has been changed effective Jnuary 1, 2000 as follows:

EJ Subsequent claims for a defined course of therapy, e.g., EPO, sodium hyaluronate, infliximab

A4556	E0781	J1260	J7500*	K0100	L4396
A4557	J0270	J1825	J7501*	K0101	L5925
A5126	J0275	J1830	J7502*	K0102	L5968
E0155	J0290	J3030	J7504*	K0104	L5988
E0158	J0690	J3240	K0031	K0105	L6693
E0450	J1100	J3370	K0065	L4392	L8435

Discontinued (deleted) Codes

HCPCS Codes K0028, K0099, and K0108 also have descriptor changes, which were effective 10/1/1999.

The Crosswalk codes are indicated below in parentheses.

Reminder – There is a 3-month grace period for discontinued codes. This grace period applies to claims received by the DMERC before April 1, 2000, which include 1999 discontinued codes for dates of service January 1, 2000 to March 31, 2000.

A4363 (A4369, A4370, A4371)	K0174 (A7009)	K0425 (A4381)	K0515 (J7642)
E1400 (E1390)	K0175 (A7010)	K0426 (A4382)	K0516 (J7643)
E1401 (E1390)	K0176 (A7011)	K0427 (A4383)	K0518 (J7644)
E1402 (E1390)	K0177 (A7012)	K0428 (A4384)	K0519 (J7648)
E1403 (E1390)	K0178 (A7013)	K0429 (A4385)	K0520 (J7649)
E1404 (E1390)	K0179 (A7014)	K0430 (A4386)	K0521 (J7658)
J1760 (J1750)	K0180 (A7015)	K0431 (A4387)	K0522 (J7659)
J1770 (J1750)	K0181 (A7016)	K0432 (A4388)	K0523 (J7668)
J1780 (J1750)	K0190 (A7000)	K0433 (A4389)	K0524 (J7669)
J7196 (J7198, J7199)	K0191 (A7001)	K0434 (A4390)	K0525 (J7680)
J7503* (J7516) *	K0192 (A7002)	K0435 (A4391)	K0526 (J7681)
K0119* (J7500)*	K0277 (A4372)	K0436 (A4392)	K0527 (J7683)
K0120* (J7501)*	K0278 (A4373)	K0437 (A4393)	K0528 (J7684)
K0121* (J7515)*	K0279 (A4374)	K0438 (A4394)	K0530 (A7017)
K0122* (J7516)*	K0284 (E0779)	K0439 (A4395)	Q0132 (E0590)
K0123* (J7504)*	K0400 (A4280)	K0503 (J7608)	ZZ001 (A9900)
K0137 (A4369)	K0401 (A5508)	K0504 (J7618)	ZZ002 (A9900)
K0138 (A4370)	K0412* (J7517)*	K0505 (J7619)	ZZ003 (A9900)
K0139 (A4371)	K0417 (E0780)	K0506 (J7635)	ZZ004 (A9900)
K0168 (A7003)	K0418* (J7502)*	K0507 (J7636)	ZZ005 (L9900)
K0169 (A7004)	K0419 (A4375)	K0508 (J7628)	ZZ006 (A9900)
K0170 (A7005)	K0420 (A4376)	K0509 (J7629)	ZZ007 (A9900)
K0171 (A7006)	K0421 (A4377)	K0511 (J7631)	ZZ008 (A9901)
K0172 (A7007)	K0422 (A4378)	K0512 (J7637)	ZZ009 (A9900)
K0173 (A7008)	K0423 (A4379)	K0513 (J7638)	ZZ011 (A9900)
	K0424 (A4380)	K0514 (J7639)	

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The classification listings contained in the Appendices Section of the manual have also been updated to include current coding recommendations for specific products. This update is included in the accompanying *Region A DMERC Supplier Manual* revision. The section contains listings for the following items:

- Enteral Nutrients
- Nebulizers
- Oral Anti Cancer Drugs
- Pneumatic Compression Devices
- Support Surfaces - Group I
- Support Surfaces - Group II
- Surgical Dressings
- Wheelchairs

For products not included on these lists, the supplier or manufacturer may contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for coding verification. The SADMERC operates a help line at (803) 736-6809 from 9:00 A.M. to 12:00 P.M. and 1:00 P.M. to 4:00 P.M. EST Monday through Friday.

Immunosuppressive Drugs - New Codes

Effective April 1, 2000, some changes are being made in the coding of immunosuppressive drugs. Several current K codes and one current J code will be replaced with J codes, as listed below.

- The new J codes will not be effective for submission to the DMERC until dates of service on or after April 1, 2000. Claims submitted with the new J codes for dates of service before April 1, 2000 will be rejected as invalid.

- Suppliers must continue to use the current K and J codes for all claims with dates of service on or before March 31, 2000. Claims submitted with these codes for dates of service on or after April 1, 2000 will be rejected as invalid.

Dates of Service On or Before 3/31/2000	**Dates of Service On or After 4/1/2000**
K0119 – Azathioprine, oral, per 50 mg	J7500 – Azathioprine, oral, 50 mg
K0120 – Azathioprine, parenteral, per 100 mg	J7501 – Azathioprine, parenteral, 100 mg
K0121 – Cyclosporine, oral, per 25 mg	J7515 – Cyclosporine, oral, 25 mg
K0122 – Cyclosporine, parenteral, 250 mg	J7516 – Cyclosporine, parenteral, 250 mg
K0123 – Lymphocyte immune globulin, 250 mg	J7504 – Lymphocyte immune globulin, 250 mg
K0412 – Mycophenolate mofetil, oral, 250 mg	J7517 – Mycophenolate mofetil, oral, 250 mg
K0418 – Cyclosporine, oral, per 100 mg	J7502 – Cyclosporine, oral, 100 mg
J7503 – Cyclosporine, parenteral, 50 mg	J7516 – Cyclosporine, parenteral, 250 mg *(Note the change in the unit of service)*

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Oxygen Concentrators – New Code

A new code has been established to bill for all oxygen concentrators.

E1390 Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate

This code is effective for claims with dates of service on or after January 1, 2000. It will be in the Oxygen payment category.

Oxygen concentrators differ in the maximum oxygen flow rate that they can deliver having an oxygen concentration of 85% or greater. Code E1390 may only be billed if the concentrator provided to the patient can deliver an oxygen concentration of 85% or greater at the maximum liter flow rate ordered for the patient.

Code E1390 will replace codes E1400-E1404 that are currently used to bill for oxygen concentrators. For patients currently using concentrators billed with these codes, a revised CMN will not be required when billing with code E1390 is begun.

A grace period exists for making the coding transition:

- Codes E1400-E1404 will continue to be required for all claims with dates of service on or before 12/31/99.
- Codes E1400-E1404 will be accepted if both (1) the date of service is on or after 1/1/00 and (2) the claim is received on or before 3/31/00.
- Codes E1400-E1404 will be rejected as invalid if both (1) the date of service is on or after 1/1/00 and (2) the claim is received on or after 4/1/00.

New HCPCS Code for Augmentative Communication Device

HCPCS Code E1900 has been established for synthesized speech augmentative communication devices with dynamic display. The new code is effective for claims with dates of service on or after January 1, 2000.

E1900 Synthesized speech augmentative communication device with dynamic display

Augmentative communication devices will be denied non-covered if billed to the DMERC.

Two New Codes Established for Miscellaneous Supplies

A permanent Level II HCPCS Code, A9900, has been newly established to replace Level III Local Codes ZZ001, ZZ002, ZZ003, ZZ004, ZZ006, ZZ007, ZZ009, and ZZ011. This code is used to describe items that are billed separately, but are components of other codes.

A9900 Miscellaneous supply, accessory and/or service component of another HCPCS code

When billing the component items for orthotics and prosthetics, the newly established HCPCS Code L9900 is to be utilized, replacing HCPCS Code ZZ005.

L9900 Orthotic and prosthetic supply, accessory and/or service component of another HCPCS "L" Code

Both of the above codes are effective for claims with dates of service on or after January 1, 2000.

Walkers – New Code

A new code has been established for a special type of walker.

E0144 Enclosed, framed folding walker, wheeled, with posterior seat

This code is effective for claims with dates of service on or after January 1, 2000. It will be in the Inexpensive or Routinely Purchased (IRP) payment category.

This code describes a folding wheeled walker which has a frame that completely surrounds the patient and an attached seat in the back. The medical necessity of this type of walker compared to a standard folding wheeled walker, E0143, has not been established. Therefore, if the basic coverage criteria for a walker are met and code E0144 is billed, payment will be based on the allowance for the least costly medically appropriate alternative, E0143.

A revision of the Walkers policy incorporating this code is included in the accompanying Supplier Manual revision.

New HCPCS Code for Tobramycin

Effective for claims with dates of service on or after January 1, 2000, the following new HCPCS code has been established:

J7682 Tobramycin, unit dose form, 300 mg, inhalation solution, administered through DME

Use code J7682 when billing the DMERC for any unit dose formulation of tobramycin dispensed for inhalation through a nebulizer. If the unit dose being dispensed to the patient does not contain 300 mg of tobramycin, bill the number of units of J7682 that accurately represents the number of mgs actually being dispensed to the beneficiary. For example, if each unit dose dispensed contains 150 mgs of tobramycin and a total of 10 unit doses are dispensed, bill only 5 units of J7682.

Billing Reminders

Walker (E0147) Billing

Please remember, when billing for a walker - code E0147, for dates of service on or after 12/1/98, you MUST bill hard copy (paper claim) and include the following information:

- Manufacturer's name
- Model name/number
- Copy of a note or other documentation from the treating physician giving a detailed description of the functional limitations which preclude the patient using another type of wheeled walker and the diagnosis causing this limitation

For further clarification, please refer to the *Region A DMERC Supplier Manual*, Chapter 14.2

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Supplier Notices

The information contained in the Supplier Notices was accurate at the time of original publication. Some of the contents may have since been updated or changed.

Billing for Immunosuppressive Drugs Following a Pancreas Transplant

Supplier Notice 99-34
October 29,1999

As you are aware, HCFA recently expanded the coverage for Immunosuppressive Drugs following a pancreas transplant. Details highlighting this coverage change have been published in both the June and September 1999 issues of *DMERC Medicare News.*

Due to the activities involved with preparation for the Year 2000, the DMERC will not be able to make system-related changes to add "Pancreas" as a transplant option on the DIF for Immunosuppressive Drugs, DMERC Form 08.02. These changes cannot be made until we have transitioned into the Year 2000.

As a result, the initial claim and DIF submitted for coverage under the DMERC Immunosuppressive Drug policy following a pancreas transplant MUST be filed hard copy (paper claim). Complete question #5 on the DIF, writing in the word "Pancreas."

This procedure must be followed until you are notified that the appropriate system changes have been made.

Miscellaneous

Helpful Hint – Mail to the DMERC

Supplier Hint

To help in the pre-processing of your paper claims, please refrain from using multiple and large staples on claims or additional documentation sent to the DMERC. This will help us to prepare your claims for processing in a more timely manner. If a fastener must be used, please use one staple in the upper right-hand corner or paper clips when applicable. If smaller pieces of paper (i.e., receipts, prescriptions, etc.) are included, please tape them to an 8½" x 11" sheet of paper.

Thank you for your assistance.

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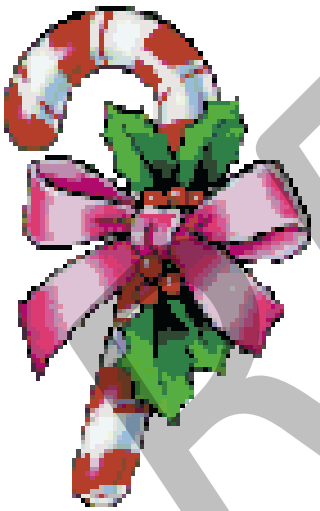
EDI

Adoption of Standard Electronic Health Care Transaction Formats in the United States

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 contain a number of requirements which will improve and simplify the administrative demands on providers of health care. Although use of electronic health care transactions has grown significantly, especially for Medicare, providers have complained that different health plans have different format requirements for transactions. Even when the same format is accepted by multiple plans, those plans usually have different coding or other completion requirements for the formats. This forces providers to be able to respond to each plan's separate requirements if the providers want to be able to interact electronically with those plans for billing, payment, eligibility, claim status query, and a number of other health care transactions. This is inefficient, expensive, and confusing.



HIPAA will remedy those complaints. You will begin to experience the benefits of HIPAA on electronic health care transactions within the next few years. As this may have some significant impact on your operations and your planning for billing/practice management systems, Medicare plans a series of educational efforts to furnish you with the information you may need to make informed choices. In addition, information will also be shared with professional associations, their publications, and national media to publicize the impact of these changes.

HIPAA Administrative Simplification Summary Background

HIPAA requires that the Secretary of the Department of Health and Human Services adopt standards for electronic transactions and data elements for those transactions, standard code sets to be used in the transactions, unique health identifiers, and security standards and safeguards for electronic information systems involved in those transactions. This article is limited to information on the HIPAA transaction standards. Unique health identifier, standard code set, and security issues will be addressed in later updates.

The following health care transaction standards are specified:

- Health claims or equivalent encounter information;
- Enrollment and disenrollment in a health plan;
- Eligibility for a health plan;
- Health care payment and remittance advice;
- Health plan premium payments;
- Health claim status;
- Referral certification and authorization;
- First report of injury;
- Coordination of benefits; and
- Attachments.

A proposed rule was published in the Federal Register on May 7, 1998, to adopt certain version 4010 electronic formats developed by the American National Standards Institute (ANSI) accredited X12N subcommittee as the national standards for each of the specified electronic health care transactions (except attachments and first report of injury) and National Council for Prescription Drug Programs (NCPDP) electronic formats for retail pharmacy transactions. Those X12N standards are the 837 (claims, encounters, and coordination of benefits), 834 (enrollment and disenrollment), 270/271 (eligibility query and response), 835 (payment and remittance advice), 820 (premium payments), 276/277 (claim status inquiry and response), and 278 (referral certification and authorization). Publication of the final rule for those transactions is expected later this

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year. The attachments transaction proposed rule is also expected to be published later this year, and a first report of injury transaction proposed rule should be published next year.

HIPAA requires that the adopted standards be implemented by virtually all health plans in the United States (including, but not only, Medicare and Medicaid) who perform the business function related to each standard transaction regardless if that function is performed electronically, in paper form, by telephone or in another mode, and by providers of health care that transmit any of these transactions electronically. Providers that exchange any of these transactions electronically with health plans must either transfer transactions that comply with the implementation guides adopted in the final rule, or contract with a clearinghouse to translate their transactions into or from the standard formats. If a provider chooses to contract with a clearinghouse for these translation services, the provider is responsible for the clearinghouse charges and the accuracy of the translations performed by that clearinghouse.

Likewise, health plans that conduct these transactions electronically must be able to receive and send standard transactions that comply with the requirements in the published implementation guides. Effective with implementation of these standard transaction formats, a plan may not require that you exchange electronic transactions of these types in any other format. Nor may you or a plan use a trading partner agreement to override, substitute or otherwise change any requirement or condition of use of any part of a standard transaction's implementation guide.

A health plan that is unable to directly exchange electronic transactions in a standard format can contract with a clearinghouse to translate incoming and outgoing transactions to comply with the standard format requirements. If a health plan chooses this option, it cannot charge providers or other clearinghouses who choose to use the standards for those translation costs. Nor may a plan delay or disadvantage processing of transactions which are submitted or issued in a standard format.

HIPAA does not require that providers submit claims or receive remittance advices electronically. Nor does HIPAA require that providers submit electronic queries and receive electronic responses for claim status and eligibility. Providers may continue to make mail and telephone inquiries if they prefer. HIPAA does, however, make it easier and more cost-effective to use electronic transactions with the expectation that these improvements will result in greater use of electronic data interchange (EDI). Medicare contractors will continue to issue free billing software for a nominal handling fee that can be used by providers to electronically bill Medicare, and to issue free PC-Print software for use with Medicare's remittance advice transactions.

HIPAA requires that the transaction standards be implemented by most health plans and "electronic" providers within 2 years of the effective date of publication of the final rule in the Federal Register. Certain "small" health plans will be allowed three years for implementation. Due to the number of providers involved and the need for system testing with those providers, Medicare expects to have a 12-15 month transition period during which electronic providers will convert to the HIPAA version of the transaction standards.

What This Means for Providers

Once the transaction standards are implemented nationally, a provider will be able to submit the same transaction in the same format to any health plan equipped for the receipt of electronic transactions of these types. Likewise, an "electronic" provider will receive transactions of these types from any plan in the same format. This will make it more cost-effective for most health care providers to use software to automatically produce standard transactions to send to plans, and to automatically post data directly to accounts receivable. HIPAA will reduce the need for manual processing in the day-to-day processing of patient account information.

However, many providers and plans may need to make some significant changes to realize the benefits of HIPAA. Once the HIPAA transaction standards are fully implemented, Medicare will no longer accept

flat-file electronic UB-92 or National Standard Format (NSF) transactions for claims. Nor will Medicare issue any electronic remittance advices in the NSF format, or exchange any electronic transactions of the type specified by HIPAA, such as eligibility queries/responses, in any version not adopted as a national standard in the final rules for Administrative Simplification transaction standards.

Where you currently use a clearinghouse to translate your outgoing or incoming electronic transactions, you can continue to use a clearinghouse capable of HIPAA standard format translation for those services. If you do not use a clearinghouse, you must choose whether to install software that can send and receive in the HIPAA transaction standard or contract with a clearinghouse for this service.

Providers that do not currently electronically transmit some or any of the transactions affected by HIPAA should re-examine their situation to see if it would be cost-effective for them to begin to use or expand their use of EDI. EDI staff at their local Medicare office can provide information about the advantages of EDI, requirements for EDI, vendors that may be able to help providers to become EDI capable, and on the impact of the HIPAA transaction standards.

Medicare carriers, other than Durable Medical Equipment Regional Carriers (DMERCs), and intermediaries are already able to receive claims in the X12N 837 format and issue remittance advices in the X12N 835 format, although in an earlier version than we expect to be adopted for national use under the final transactions rules for HIPAA. In fact, the X12N 835 is the only electronic remittance advice intermediaries may send. Medicare contractors are also able to accept eligibility inquiries electronically and respond electronically, but not in an X12 format, and will need to convert to use of the X12N 270/271 formats for this. Medicare has not previously required that contractors use any of the other electronic transactions mentioned in HIPAA, but Medicare will implement those that apply to Medicare operations when the Administrative Simplification transactions are effective. DMERCs will also convert to sole use of the HIPAA X12N standards at that time.

What Medicare Providers Can Do Now

Providers and their clearinghouses that would like to get an early start learning about the X12N transactions, or that are otherwise considering changing from their current use of an electronic UB-92 or NSF, may wish to consider upgrading after January 2000 to the latest X12 claim and/or remittance advice version available from their Medicare carrier or intermediary. While not identical to the HIPAA transaction version that will likely be implemented, they are very similar. Use of a version 3051 claim or 3051.4 remittance advice now should make the subsequent transition to the HIPAA version much easier for those providers, and familiarize those providers with the X12N format rules and syntax, facilitating use of the other HIPAA transactions as they are implemented by Medicare and other payers. This would probably also put those providers into position to transition to the HIPAA transaction standards at the earliest possible time, allowing them to be the first to realize the benefits of Administrative Simplification.

How to Get More Information

Medicare will issue additional information to you regarding the HIPAA transaction standards as the final rules are published. Providers that would like to obtain more information about EDI under Medicare and HIPAA may also want to consult the following Web sites:

EDI standards currently used by Medicare
www.hcfa.gov/medicare/edi/edi.htm

X12N version 4010 transaction implementation guides— www.wpc-edi.com/hipaa

Text of Administrative Simplification law and regulations— aspe.os.dhhs.gov/admnsimp

X12N meeting and workgroup meeting information and minutes—www.disa.org
(select the Insurance, X12N, Subcommittee)

Providers that would like to increase their use of EDI, including use of X12N transactions already implemented by Medicare, should contact the Region A DMERC EDI Help Desk at telephone number (570) 735-9429.

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Electronic Submitters Who Have Y2K Tested

We would like to thank the following providers who have submitted electronic claims for our Year 2000 testing effort: (an updated list is available on our website at www.medicare-link.com)

1st Choice Medical Supply

20/20 Opticians

ABBA Medical Supply Inc.

Able Home Care Medical Supply, Inc.

Advacare Home Services, Inc.

Advanced Optics

AJ's Automated Claims

Alpha Medical, Inc.

Americair Franchises

American Oxygen Company FKA American Vital Care Co., Inc.

Amputee Treatment Center

Armstrong Country Health Center

Avenue Medical

Bannon Pharmacy, Inc.

Banville Optical, Inc.

Belmont Drugs & Surgical/ M & L Pharmacy

Bennett Surgical

Billie A. Bonder DPM

Birchwood Nursing Home

Blair Care Home Health Care

Bloomsburg Medical Supply

Borderview Manor

Bracey Pharmacy, Inc.

Calais Home Care, Inc.

Care of CNY

CAU (Computer Application Unlimited)

Clark Respiratory & Medical Supply

Cliffside Park Eye Associates

Colburn Orthopedics, Inc.

Cole Care Inc.

Cole's Pharmacy

Cooke & Burnell Orthopedics Inc.

Corwin Optical

Council Optometric Centers, Inc.

Dataline Inc.

Del Negro Pharmacy & Medical Supply/Medicare Software

DG Respiratory Asssoc., Inc.

Drug Surge Inc.

Durable Medical Equipment Sales Inc. dba A 2 Z Medical Supply

East Neck Nursing & Rehabilitation Center

Elwyn Pharmacy

Envoy - Synaptek

Ephrata Medical Equipment

Express Medical

Falmouth Prescription Center

Fastrack Healthcare Systems, Inc.

Fittleworth Medical

Gericare Providers

Gold Star Pharmacy dba The Medicine Shoppe

Grand View Medical Company

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Harrico Galler Drug Corp.

Harry J. Lawall & Son Inc.

Hartland Promotions dba Hartland Prescription Service

Hayes Prosthetics Inc.

Health Care Solutions, Inc.

Healthcare Unlimited

Hixenbaugh's Drug Store

Home Medical Supply, Inc.

Howell J. Smith

Ideal Health Care, Inc.

Imagicon, Inc.

Inglis Durable Medical Equipment Co.

In-Home Medical & Respiratory Service

Interphase Medical Equipment

J. T. Murdoch Shoes

Jersey Drugs Inc.

John Tag's Pharmacy

K B T Corporation

Keystone Medical Equipment

Kim's Orthopedic Shoes, Inc.

Kurt Sauer Opticians Inc.

Laurel Medical Supplies, Inc.

Lewistown Pharmacy, Inc.

Liberty Orthotics, Inc.

M & M Prosthetics & Orthotics Mobile Services, Inc.

Majors Medical Supply

Management by Information

Marra's Pharmacy, Inc.

Massachusetts Prosthetics

Medcure

Medicare Equipment Center/Surgical Medical Equipment Corp

Medi-Rents, Inc.

Medox Inc.

Millersburg Pharmacy, Inc.

Mt. Holly Surgical Supply

MYS Respiratory Eq. Co. Inc.

Nichole Medical Equipment & Supply

North Atlantic Medical Services

Northeast Homecare

Nu-Care Systems, LTD.

Nunnery Orthotic & Prosthetic Technologies

Palmer Pharmacy

PC Solution Software Development Inc.

Pharmacy Value

Phipps Health Care Repare

Physician Computer Network, Inc.

Prosthetic & Orthotic Associates, Inc.

QS/1 Data Systems

Red Cross Pharmacy

Rosie's Comfort Shoes Inc.

Santo Medical Supplies Co.

Scaglione Prothetics Inc.

Scoville Prosthetics, Inc.

Shafer's Pharmacy

Shelby Medical Inc.

Slate Belt Medical Equipment & Supplies

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Somerset Family Eyecare

Standard Pharmacy and Medical Supplies

Sunshine Surgical

Tepper Pharmacy

The Figure 8

The Medicine Shoppe/Jarkis Inc.

The Ortho Remedy, Inc.

Thomas Respiratory Health Care

United Respiratory Care

Upstate Home Respiratory Equipment, Inc.

Vinco Pharmacy

W. Scott Taylor Surgical

Wakeem Inc. dba Bell Apothecary

Westport Apothecary Inc.

Womens Surgical Boutique dba Womens Boutique

Y & G Luckstone, Inc.

Zive Pharmacy, Inc.

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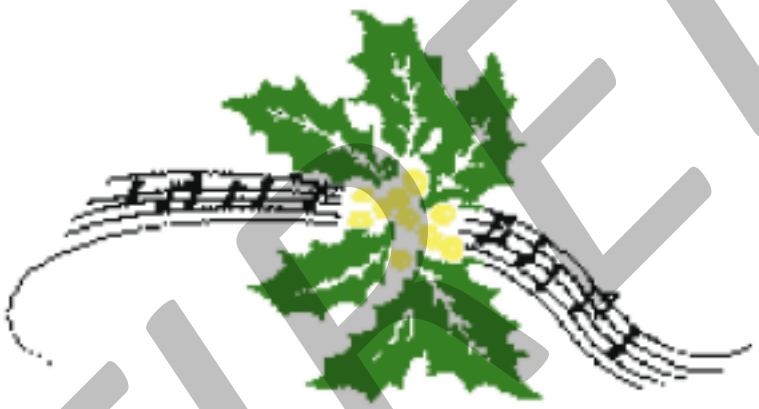
Seasons Greetings



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