

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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CMN Reject Report

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 conditions listed below, the claim will be accepted into the system. It will be 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 Duplicate. Already have an initial certification for this procedure code with the same dates.
- 3031 Initial Date less than 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 less than previous. This could mean one of two things:
1. This certification is a duplicate of a previous revision/recertification sent in on a previous claim.
 2. 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 EDI recertification is not equal to the Initial Date on the CMNs already on file.
- 3048 Cannot recertify discontinued CMNs. The EDI submitter tried to recertify a CMN that has been placed into a discontinued status within our system.
- 3052 CMN CLSD - NON REV. When revisions to closed CMNs are received, the system will reject the CMN because of one of the following reasons:
- Capped Rental - purchased 13th month
 - Discontinued

- Maintenance only
- Medical necessity length met
- Reasonable purchase price reached
- Recertification not received (PEN/oxygen)

This report also shows the corrected HIC number when the submitted HIC number was not correct.

The CMN Reject Report is sent to all EDI submitters when CMNs associated with accepted EDI claims are rejected by the VMS system.

CMN rejects should be directed to our Provider Services Unit at 570-735-9445.

(September "98" Newsletter, page 14 - Supplier Notice 98-14.)



Get Your Supplier Notices and Alerts via Email



The Region A DMERC is pleased to announce the availability of our listserve (an electronic mailing list). Once subscribed to our listserve, you will receive our supplier notices and supplier alerts via email as they are issued.

To subscribe to the Region A DMERC listserve, send an email to commands@lr.listserve.com with the words **SUBSCRIBE DMERCA** in the body of the message.

The e-mail must *not* contain a subject or any other text in the message. You will receive a confirmation by the listserve if you sent the email properly.

For more detailed instructions, visit our web site at www.medicare-link.com.

**Seminar Information can be found
on pages 25-26**

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Internet Address

Region A DMERC Office • www.medicare-link.com
HCFA Office • www.hcfa.gov

HCPCS

HCPCS Helpline (SADMERC)

Effective November 1, 1998, the HCPCS Helpline representatives at the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) will be available to answer your coding questions from 9:00 am - 4:00 pm EST. In addition to assisting with proper code recommendations, the representatives are able to address your fee schedule requests. Please note the SADMERC is not able to assist customers with allowables for items not on the fee schedule (e.g., reasonable charge, individually considered).

Questions and inquiries regarding HCPCS code usage and allowables for items on a fee schedule should be directed to:

HCPCS Helpline (803) 736-6809
or

SADMERC/HCPCS Unit
P.O. Box 100143
Columbia, South Carolina 29202-3143

What is a Coding Verification Review?

The SADMERC provides assistance to suppliers and manufacturers to ensure the proper coding of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. When suppliers or manufacturers are unsure of the correct HCPCS code for a product, they should direct their inquiry to the SADMERC. A Coding Verification Review will be initiated (if the SADMERC has not previously reviewed the product). To initiate a Coding Verification Review, you will be asked to submit, in writing, the information below for each product to be reviewed. After all necessary documentation is received, a review will be initiated, and you will receive a letter in-

structing you whom to contact if you have questions while your product is in review. This also serves as a confirmation that the SADMERC has received the necessary documentation. An analyst at the SADMERC reviews the product and makes a recommendation. The four DMERCs also receive your product literature, review the product, and each make an independent recommendation. The SADMERC and the four DMERCs will discuss the item and reach a consensus decision regarding coding. The SADMERC notifies the supplier or manufacturer of the determination. The Coding Verification Review process takes approximately 90 days, but many are completed sooner.

If you have any questions concerning the Coding Verification Review or the SADMERC, please contact our Helpline at 803-736-6809 from 9:00 a.m. - 4:00 p.m. EST.

Required Documentation Necessary for HCPCS Coding Verification Reviews

Please note that **all** reviews require 5 sets of all the following information be sent to the SADMERC:

- Wholesale and suggested retail cost of the item.
- A list of the monthly/weekly/daily rental charges for item, if applicable.
- Documentation of the FDA's current classification of the item.
- Date that the item was available on the US market.
- Pictures of the item (marketing literature).
- A statement of the HCPCS code you feel best meets the description of your product.

- A list of all Universal Product Codes (UPC) or Universal Product Numbers (UPN), if available, for each product to be reviewed.

In addition to the information above, please include 5 sets of the items listed below in the category that best describes your product.

Support Surfaces/Seating Cushions

- A description and exact dimensions of the product. This should include the height, depth, and width of all components, and the combined total of all components. Include a cut-away diagram.
- A description of how the product functions and the indications for use of this product.
- Clinical studies and case studies that have been performed using the product.
- Any additional pressure testing results.
- Warranty information for all parts and accessories of the product.

Surgical Dressings

- An exact description and sizes of all layers and component parts of the dressing.
- A listing of all ingredients of the product and the amounts present.
 - A List of all sizes in which the dressing is available.
 - A list of all indications for use of your product (for multiple layer dressings, include indications and purposes of each layer or component of the dressing).
 - Include 5 (five) samples of the dressing.

Medications and Enteral or Parenteral Nutrition Products

- The generic name of all drugs and pharmaceutical items.
- For all pharmaceutical items: manufacturers' name, NDC number, indications, actions, dosage, administration recommendations, and how it is supplied.
- A list of all ingredients, and portions of each, for all enteral and parenteral products.
- A list and description of the similarities to other enteral or parenteral products on the market.

Orthotics and Prosthetics

- An exact description including how it is made and what materials were used to make it.
- A description of where on the body the device or item is to be worn or used.
- A list of the indications for use of the item and how the patient is taught to apply.

Durable Medical Equipment and Medical Supplies

- An exact description of the item. Include all component parts and/or accessories.
- A description of how this equipment operates and functions.
- A list of all supplies necessary for the use and operation of the equipment.
- A list of the indications for use of the equipment.
- Operations and Patient Instruction Manuals.
- Warranty information for the equipment and component parts.
- The recommended duration of use for all supplies associated with the equipment.
- Results of clinical studies that have been performed using this equipment.

Sizes

Materials

Instructions

Billing

NSC Inactivation

The following information is being supplied to providers for inactivation of an NSC number due to:

- The supplier considering to no longer participate in the Medicare program, or
- The supplier not billing for four consecutive quarters, the NSC will inactivate your NSC number.

If your supplier number becomes inactive, you must inform the beneficiary that Medicare will not reimburse them for items you supply, and if they wish to receive Medicare reimbursement, they should go to another supplier. You should also post a sign that states you are not a Medicare provider.

The following also applies:

Section 1834(j) of the Social Security Act states that, with the exception of medical equipment and supplies furnished incident to a physician's service, no payment may be made by Medicare for items furnished by a supplier unless the supplier has a valid Medicare billing number. Therefore, any expenses for items you supply to a Medicare beneficiary on or after the effective date of the inactivation (or revocation) of your billing number are your responsibility and not the beneficiary's, unless you have proof that you have notified the beneficiary in accordance with section 1834(a)(18)(ii) of the Social Security Act, and the beneficiary has agreed to take financial responsibility if not covered by Medicare. You will be required to refund on a timely basis to the beneficiary (and will be liable to the beneficiary for) any amounts collected from the beneficiary for such items. If you fail to refund as required, you are subject to Civil Monetary Penalties under 1834(j)(4) of the Social Security Act.

If you have any questions regarding your NSC number, please contact the National Security Clearinghouse at 803-754-3951.

Surrogate Unique Physician Identification Number (UPIN) NPP000

Effective April 1, 1999, claims containing the surrogate Unique Physician Identification Number (UPIN) "NPP000," used for: Nurse Practitioners (NP); Clinical Nurse Specialists (CNS); and Physician Assistants (PA), will be returned as unprocessable. The Health Care Finance Administration (HCFA) has discontinued the use of this surrogate UPIN. NPs, CNSs and PAs have been notified by HCFA and have been issued a permanent UPIN for immediate use.

Services of a NP or a CNS who is working in collaboration with, but independent of a physician would be considered covered services as defined in 1861(s)(1) and 1861(s)(2)(A). Therefore, a NP or CNS who is treating the beneficiary can order or prescribe items of durable medical equipment, orthotics, prosthetics and supplies (DMEPOS) and can complete Section D of the Certificate of Medical Necessity (CMN) if he or she is permitted to prescribe items of DMEPOS by the State in which the services were rendered.

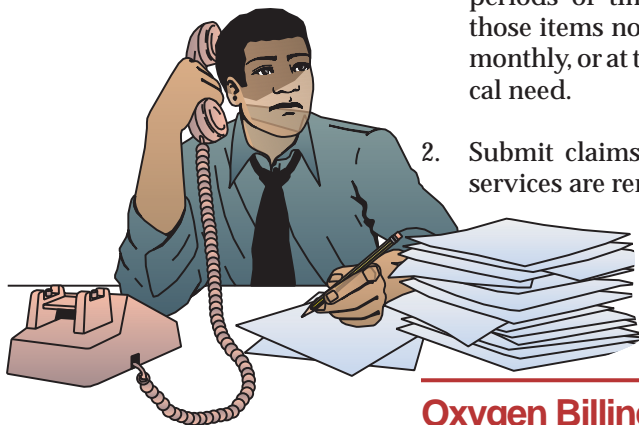
The NP and CNS must bill using their own provider number, and they must attest, the same as a physician, that they have treated the beneficiary and that all information presented in Section B of the CMN, or on the order, is true, accurate, and complete to the best of their knowledge. The name and UPIN of the NP or CNS are required on the CMN.

DMERC Billing Procedures

In an effort to provide efficient service, we would like to remind suppliers of a few correct ways to help ensure timely processing of claims.

1. If items are rendered for continuous periods of time, submit claims for those items no more frequently than monthly, or at the conclusion of medical need.
2. Submit claims in the sequence that services are rendered.
3. Claims should only be submitted when delivery has been made as a result of a request from the beneficiary, physician, or designated representative. The supplier should not automatically mail or deliver items on a predetermined dispensing basis.

These procedures will assist us in providing quality service to you, as well as preserve Medicare program resources.



Oxygen Billing Requirements - "Q" Modifiers

When billing the Region A DMERC for oxygen and oxygen equipment, the correct HCPCS codes and corresponding "Q" modifiers must be billed in order to assure proper adjudication of claims. Failure to bill correctly may result in either a decrease in payment or a complete denial of the claim.

For example, claims billed for stationary equipment with a liter flow of less than 1 LPM must be billed with a "QE" modifier. Claims billed for stationary oxygen equipment with a liter flow greater than 4 LPM must have the "QG" modifier added to the stationary procedure code if *no portable oxygen* is prescribed. Claims billed for stationary oxygen equipment with a liter flow of greater than 4 LPM must have the "QF" modifier added to the *stationary* procedure code if portable oxygen is prescribed.

Examples:

Code	Description
E1400QE RR	Liter flow < 1 LPM
E0439QG RR	Liter flow > 4LPM and <i>no</i> portable oxygen prescribed
E1403QG RR	Liter flow > 4 LPM and <i>no</i> portable oxygen prescribed
E0439QF RR	Liter flow > 4 LPM and portable oxygen

Furthermore, when billing for an oxygen concentrator when the liter flow is greater than 4 LPM, the appropriate procedure code must be billed to signify an oxygen concentrator which has the capability to produce a liter flow greater than 4 LPM.

Examples

Code	Description	Validity
E1400QG RR	Flow rate \leq 2 LPM	Not Valid
E1402QG RR	Flow rate \leq 4 LPM	Not Valid
E1403QG RR	Flow rate \geq 4 LPM \leq 5LPM	Valid

If a claim is received by the Region A DMERC without the appropriate procedure codes and corresponding "Q" modifiers, it may be reduced to accommodate the method billed or be denied.



Miscellaneous

Enforcement of Child Support Provisions of the Debt Collection Act of 1996

The Debt Collection Act of 1996 and Executive Order 13019 allow delinquent child support payments to be offset from Federal payments. The Health Care Financing Administration (HCFA) is working with the Administration for Children and Families to identify individuals delinquent in their child support obligations who receive Federal payments and to consider withholding Federal payments, if appropriate. HCFA also plans to coordinate its efforts with the States, which have authority under recent welfare reform legislation to revoke licenses of health professionals who are delinquent in child support payments.

OIG Scam Warning

Please be aware of one of the latest “scams” involving power wheelchairs and scooters (POVs). According to an article recently published in the *Tampa Tribune*, 25 medical supply companies in Pasco, Pinellas, and Hillsborough counties in Florida have been accused of a massive fraud scheme. Door-to-door salesmen offered power wheelchairs to the elderly, but either delivered nothing or later swapped them for power operated vehicles (POVs). They frequently enticed the beneficiaries to accept delivery by offering other unnecessary equipment, such as beds or seat-lift mechanisms.

Several of the companies involved have approached other suppliers throughout the United States, offering a “partnership” to distribute more POVs. Be very careful about getting involved in such deals. You could set yourself up for recoupments, sanctions, or even criminal charges. Remember, if it looks too good to be true, it probably is!

Provision of Items With Conflicting Coverage Criteria

In some situations, the Medicare coverage criteria for one type of DMEPOS item is in conflict with the Medicare coverage criteria for a different DMEPOS item. When two such items are supplied to the beneficiary, this raises the question of whether the beneficiary meets the coverage criteria for either item. For example, a beneficiary may have been provided a wheelchair, for which coverage criteria states that the patient must be bed or chair confined. If the same beneficiary either subsequently or at the same time presents to the supplier a prescription for a walker, there is an inherent conflict in providing this new item since Medicare coverage policy for walkers specifies the patient must be ambulatory. In these situations, we recommend that the supplier maintain in their file evidence that substantiates a change in the beneficiary's medical condition or justifies the concurrent coverage for such items, based on Medicare policies. This information may be submitted with the claim; it should be submitted to the DMERC if requested, or with an appeal if the claim(s) for one or both items is denied.

Update on CO-18 Denials

The CO-18 denials that some suppliers may have received since the VIPS transition have been analyzed by the Region A DMERC. Of the 121,981 claims denied, 20,702 have been identified as erroneous and have been adjusted for payment. The remainder of the claims were correctly denied as duplicate submissions.

Assignment Violation

Region A is still receiving numerous complaints regarding assignment violations. The beneficiary is paying in full for the service, and either the claim is submitted non-assigned and we deny the claim for assignment violation, or the claim is submitted assigned and we pay the provider. If you are a participating provider, please verify if the item being sold is for a Medicare beneficiary and follow the correct procedures.

Refer to Section 2.7 (page 2-19) of the *Supplier Manual*.



Beneficiary Right to Itemized Statement for Medicare Items and Services

A. Requirements of the Law

Effective January 1, 1999, section 4311(b) of the Balanced Budget Act of 1997 gives beneficiaries the right to submit a written request for an itemized statement from their provider/supplier for any Medicare item or service. The law requires that providers/suppliers furnish the itemized statement within 30 days of the request, or they may be subject to a civil monetary penalty of \$100 for each unfulfilled request. If an itemized statement is received, the beneficiary may request the Medicare contractor to review specific issues (i.e., services not provided, billing irregularities, and appropriate measures to recover any amount inappropriately paid).

Medicare contractors currently issue beneficiaries an Explanation of Medicare Benefits (EOMB) or a Medicare Summary (MSN). Information that may be listed include the following: date(s) of services, a description of services provided, number of services provided, benefit days used, noncovered charges, deductible and coinsurance, beneficiary liability, amount charged, claim number, name of provider/supplier submitting the claim, claim total paid by Medicare and referring physician (if applicable). Other information that may be included are deductibles, appeal rights or notices, and explanatory notes and general information regarding the specific claim. On April 1, 1999, at most Medicare contractors, these notices will begin to include the following statement: "You have a right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital or any other health supplier or health professional. Please contact them directly in writing if you would like an itemized statement." The remain-

ing Medicare contractors will print this message beginning July 1, 1999.

B. Guidance Concerning the Format and Substance of the Itemized Statement

Included below are suggestions regarding the types of information that might be helpful for the beneficiary to receive on an itemized statement. We hope this information will enable the beneficiary to reconcile the itemized statement with the Medicare notice. These are recommendations only. Since most providers/suppliers have established an itemized billing system for internal accounting procedures and billing of other payers, the furnishing of an itemized statement should not pose a significant additional burden. However, some providers/suppliers may not regularly create or furnish hardcopy itemized statements and may wish to reexamine their internal billing and tracking process to ensure that it has the capability to comply with this new requirement. Providers/suppliers should not charge beneficiaries for the itemized statement.

Itemized Statement Recommendations:

- Name of beneficiary,
- Date(s) of services,
- Description of item or service furnished,
- Number of services furnished,
- Provider/supplier charges,
- An internal reference or tracking number.

If the claim has been adjudicated by Medicare, additional information that can be included on the itemized statement are:

- Amounts paid by Medicare,
- Beneficiary responsibility for co-insurance,

- Medicare claim number.

The statement should also include a name and a telephone number for the beneficiary to call if there are further questions.

C. Reconciliation of the Itemized Statement with the MSN/EOMB

After receiving an itemized statement, beneficiaries may attempt to reconcile it with the MSN or EOMB. In situations where there are questions, especially involving some services and payment methods, providers/suppliers are requested to assist beneficiaries in understanding any differences between the two documents.

In addition, although Medicare contractor customer service representatives may not have a copy of the itemized statement, they will also answer any beneficiary inquiries regarding the EOMB/MSN and attempt to reconcile it with the itemized statement. Where appropriate, customer service representatives will attempt to resolve any questions by generally explaining applicable Medicare reimbursement rules, (prospective payment systems, revenue codes, bundling, interim rates, HCPC/CPT codes, etc.).

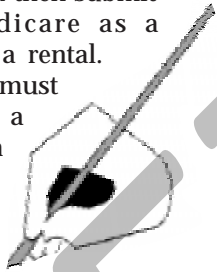
D. Beneficiary Right to Request Review of the Itemized Statement

Beneficiaries may submit a written request to their Medicare contractor for a review of a claim based on information they provide from their itemized statement. The request should identify the specific items or services that the beneficiary believes were not provided as claimed, or any other billing irregularity (including duplicate billing). A review will be conducted into the matter by the Medicare contractor and providers/suppliers may be requested to assist in the review of the itemized statement/Medicare claim. Contractors will review and take appropriate actions to resolve the complaint.

Capped Rental Items

Region A is receiving a large volume of complaints from beneficiaries who are paying up-front for the cost of capped rental items. We are seeing this mostly for nebulizers and wheelchairs, but this situation is not limited to those items.

As a reminder, capped rental items cannot be billed to beneficiaries as a purchase and then submitted to Medicare as a purchase or a rental. These items must be billed as a rental to both Medicare and the beneficiary.



Delivery of DMEPOS Items Prior to Hospital Admission

DMEPOS items that will be used initially in the hospital should not be delivered to a patient prior to the hospital admission. These items should not be billed to the DMERC. Any item initially used in the hospital is considered included in Medicare's payment to the hospital. The supplier must seek reimbursement for the item from the hospital. This would be true even if the item is custom fabricated - e.g., a brace that is applied after spinal surgery, etc.

Those items delivered to a patient in the hospital up to two days before discharge to home, for purposes of fitting or training of the patient on its use in the home, may be billed to the DMERC. (Refer to article "Delivery of DMEPOS Items prior to Discharge" in Region A, *DMERC Medicare News*, December 1998, page 4.)

Lower Limb Prosthesis Reminder

Lower Limb Prostheses codes require the RT and/or LT modifier. In addition, when replacement of the entire prosthesis or socket is billed, the claim must be accompanied by an explanation of the medical necessity of the replacement.

Effective May 1, 1999, assigned claims for Lower Limb Prostheses submitted without the appropriate RT or LT modifiers will be rejected as an invalid code. Replacement prostheses without supporting medical necessity documentation will be denied as not medically necessary. See "Lower Limb Prosthesis" policy in the *Region A DMERC Supplier Manual* for additional information.

Supporting documentation may be entered into the HAO record of EMC claims.

Policy Reminder: Home Blood Glucose Monitors

It is important to remember when submitting claims for blood glucose monitors with special features (E0609), that physician documentation of visual acuity must specifically state:

- The numerical results of an eye examination (e.g., 20/400), and
- That this result represents "best corrected" vision.

If documentation involves use of the terms "legally blind," or "totally blind," the claim must include a statement of the beneficiary's most recent eye examination from an ophthalmologist or optometrist.

Claims lacking these documentation details of the patient's impaired visual acuity will be paid at the least costly medically necessary alternative (E0607).

Refer to "Home Blood Glucose Monitor" policy for more information.

Home Glucose Monitoring Policy Revision

The Home Glucose Monitor Policy has been revised once again and is contained in this issue of the *DMERC Medicare News*. The revision involves changes with required documentation of utilization of blood glucose strips and lancets in excess of the amounts listed as usually medically needed. The effective date of the policy is still October 1, 1998.

Ankle-Foot Orthoses vs. Foot Orthotics - Coding

The DMERC has identified suppliers who are incorrectly billing codes for ankle-foot orthoses when what they are providing are foot orthotics. Ankle-foot orthoses (AFOs) are items that provide significant immobilization or stabilization of the ankle joint. Orthoses correctly coded as L1900, L1910 -L1990, and L2102-L2116 extend to near the top of the calf. Orthoses correctly coded as L1902-L1906 extend well above the ankle and are laced or otherwise fastened around the lower leg above the ankle.

Foot orthotics are shoe inserts that provide support and/or pressure reduction for the foot. Though they may provide some positioning or “stability” for the ankle, foot orthotics do not extend above the ankle and do not provide the immobilization or stability provided by an AFO. The correct codes for foot orthotics provided for patients without diabetes are L3000 - L3090. These items are noncovered by Medicare except when used in shoes which are permanently attached to a covered brace. (See Orthopedic Footwear policy for more information.) Multiple density foot orthotics used in the management of diabetic foot problems are coded A5502. (Refer to Therapeutic Shoes for Diabetics policy for more information.) Questions concerning the appropriate code to use for a particular item should be directed to the Statistical Analysis DMERC (SADMERC).

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 Identification Claim 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 *Supplier Manual*.
- When requesting a Review of an Initial Claim Determination involving a Certificate of Medical Necessity (CMN), be sure to complete all required fields. Make sure all questions on the CMN have been answered. Be sure that the CMN includes the physician's address, as well as the physician's signature with 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 National Supplier Clearinghouse (NSC) number and the Unique Physician Identification Number (UPIN) number should be documented on the Certificate of Medical Necessity as well as the initial claim form. Refer to Section 12.7, pp. 54 - 69 of the *Supplier Manual*.
- When including Explanations of Benefits 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.
Refer to: Supplier Notice 98-24

Professional Relations/ Customer Services

Frequently Asked Questions

Diabetic Supplies – Does Medicare cover diabetic supplies for both insulin and non-insulin dependant beneficiaries? Are insulin and syringes covered under Medicare?

Effective July 1st 1998, Medicare coverage for glucose monitors and related accessories and supplies was expanded to cover both insulin and non-insulin treated diabetics.

Insulin itself and syringes are not covered by Medicare.

Refer to: Home Blood Glucose Monitor
Policy
Supplier Notice 98-09

Why were claims denied for missing information when the claims were billed the same as previously paid claims?

Claims denied as due to use of incorrect/incomplete/missing modifiers.

Refer to: Supplier Notice 98-40 Electric
W/C Clarification
Supplier Notice 98-22
Supplier Notice 98-21

When to Call Professional Relations/Customer Service

First Contact for Your Questions:

ARU/VPIQ For Claim Inquiry /Status

Contact Customer Service for:

- Claim Inquiry /Status
- Coverage Issues
- Policy Information
- General DMERC Information

Contact Your Ombudsman for:

- Broad Product Related Issues
- Issues Affecting Multiple Suppliers
- Recurring Issues

New Region A DMERC Direct Dial Phone Numbers

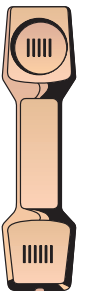
Effective March 15, 1999, providers will be able to dial a specific department to inquire about any issues they may have. The following units will have their own phone lines:

Accounting Unit	(570) 740-9002
Medicare Secondary Payer Unit	(570) 740-9001
Adjustment/Review Unit	(570) 740-9003

The Customer Service Unit can still be reached at (570) 735-9445.

As a result of the successful transition to the VIPS computer system and substantially reduced hold times, our toll-free provider services phone line will be eliminated, also effective March 15, 1999.

Additional phone lines may be implemented in the future.



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.

Correction

Supplier Notice 98-33 November 12, 1998

Supplier Notice 98-32 contained an error. The second paragraph, second sentence, should read:

Claims processed that generate a payment to the beneficiary will result in issuance of an immediate MSN with the check.

We apologize for any inconvenience this may have caused.

Addendum

Supplier Notice 98-34 November 12, 1998

Enclosed is an addendum to the attachment of Supplier Notice 98-25.

Please disregard the previous memo and begin use of the attached immediately.

To: Treating Physicians
From: United Healthcare-Region A DMERC
Subject: Certificate of Medical Necessity Completion

The Region A DMERC processes all claims for durable medical equipment, orthotics, prosthetics and supplies for Medicare beneficiaries in the 10 northeastern states. Certain items billed to the office cannot be processed without the necessary medical documentation. One very important piece of medical docu-

mentation is a Certificate of Medical Necessity. Section B3 3312 of the Medicare Carriers Manual (MCM) states, "For certain items or services billed to the DME Regional Carrier (DMERC), the supplier must receive a signed Certificate of Medical Necessity (CMN) from the treating physician."

Section B3 3041 of the MCM pertains to mandatory claim submission and states, "Section 1848 (g)(4) of the Social Security Act...prohibits physicians and suppliers from imposing a charge for completing and submitting a claim to Medicare." The Certificate of Medical Necessity is considered part of the actual claim; therefore, the physician cannot impose a charge for its completion.

It is your responsibility to provide the supplier with all the necessary medical information for the item(s) that you order. Please review the attached Certificate of Medical Necessity and upon completion return it to the supplier as soon as possible. Please be sure to complete the following information in Section B: estimated length of need, the appropriate ICD-9 codes and all questions. Section D must contain your original signature and date of completion.

When all the necessary medical documentation for a Medicare claim is not received by the supplier in a reasonable time frame, the claim cannot be submitted to the DMERC for processing. This can cause payment delays of Medicare claims, either for the supplier or your patients, depending on the assignment agreement.

Thank you in advance for your prompt attention to this important matter.

Tips For Adjudicating Claims

Supplier Notice 98-35 November 16, 1998

The purpose of this notice is to address claim adjudication by explaining the correct steps to be taken given various initial denials.

(1.) Medical Review/Utilization Denials:

Claims reflecting any of the following denials on your Remittance Notice **cannot** be resubmitted. Resubmission of the claim may result in a CO-18 (DUPLICATE DENIAL). If you do not agree with a Medical Review Utilization denial, you must request a formal review for the denial to be reconsidered. **Please include the HICN, date of service, claim control number and a statement indicating why you disagree with the denial, along with any supporting documentation.**

- PR- PATIENT RESPONSIBILITY
46- THIS (THESE) SERVICES IS (ARE) NOT COVERED.
- CO- CONTRACTUAL OBLIGATIONS
46- THIS (THESE) SERVICES ARE NOT COVERED.
- CO- CONTRACTUAL OBLIGATIONS
B5- CLAIM/SERVICE DENIED/REDUCED BECAUSE COVERAGE GUIDELINES WERE NOT MET OR WERE EXCEEDED.

CO- CONTRACTUAL OBLIGATIONS
50- THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A "MEDICAL NECESSITY" BY THE PAYER.

CO- CONTRACTUAL OBLIGATIONS
57- CLAIM/SERVICE DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, OR THIS DOSAGE.

CO- CONTRACTUAL OBLIGATIONS
107- CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PAID OR IDENTIFIED ON THE CLAIM.

CO- CONTRACTUAL OBLIGATIONS
114- PROCEDURE/PRODUCT NOT APPROVED BY THE FOOD AND DRUG ADMINISTRATION.

PR- PATIENT RESPONSIBILITY
B7- THIS PROVIDER WAS NOT CERTIFIED FOR THIS PROCEDURE/ SERVICE ON THIS DATE OF SERVICE.

(2.) Medicare Secondary Payer Denials:

Claims reflecting any of the following denials on your Remittance Notice **cannot** be resubmitted. Resubmission of the claim may result in a CO-18 (DUPLICATE DENIAL). If you do not agree with a Medicare Secondary Payer denial, you must forward you request for reconsideration to the attention of the Medicare Secondary Payer Unit. **Please include a copy of the Remittance Notice, the HICN, date of service, claim control number and a statement indicating why you disagree with the denial, along with any supporting documentation.**

PR- PATIENT RESPONSIBILITY
19- CLAIM DENIED BECAUSE THIS IS A WORK RELATED INJURY AND THUS THE LIABILITY OF THE WORKER'S COMPENSATION CARRIER.

PR- PATIENT RESPONSIBILITY
20- CLAIM DENIED BECAUSE THIS INJURY IS COVERED BY THE LIABILITY CARRIER

PR- PATIENT RESPONSIBILITY
21- CLAIM DENIED BECAUSE THIS INJURY IS THE LIABILITY OF THE NO-FAULT CARRIER.

PR- PATIENT RESPONSIBILITY
22- CLAIM DENIED BECAUSE THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.

CO- CONTRACTUAL OBLIGATIONS
23- CLAIM DENIED/REDUCED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER AS PART OF COORDINATION OF BENEFITS.

PR- PATIENT RESPONSIBILITY
23- CLAIM DENIED/REDUCED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER AS PART OF COORDINATION OF BENEFITS.

PR- PATIENT RESPONSIBILITY
23- CLAIM DENIED/REDUCED BECAUSE CHARGES HAVE BEEN PAID BY ANOTHER PAYER AS PART OF COORDINATION OF BENEFITS.

PR- PATIENT RESPONSIBILITY
38- SERVICE NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK) PROVIDERS.

(3.) Information or Invalid Information Denials:

Claims reflecting the following must be resubmitted.

CO- CONTRACTUAL OBLIGATIONS
16- CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION

CO- CONTRACTUAL OBLIGATIONS
B17- CLAIM/SERVICE DENIED BECAUSE THIS SERVICE WAS NOT PRESCRIBED BY A PHYSICIAN, NOT PRESCRIBED PRIOR TO DELIVERY,

THE PRESCRIPTION IS INCOMPLETE, OR THE PRESCRIPTION IS NOT VALID.

(4.) Adjustment Requests:

An adjustment can be requested when an error was made by the DMERC that caused the denial. Please forward adjustment requests to:

United HealthCare Insurance Company
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: **Adjustment**

There is no need to call the Provider Services Unit prior to submitting an adjustment request. If the error was, in fact, made by the DMERC, we will make the correction. If the claim was processed correctly, you will be notified. If a Medical Review/Utilization Denial is not overturned, you will receive an affirmation letter from the Review Department, indicating what your appeal rights are. Refer to Supplier Notice 98-24.

(5.) Incorrect CO-18 Denials:

The DMERC is in the process of adjusting all incorrect CO-18 denials. Our goal is to complete this by December 31, 1998. Incorrect CO-18 denials occurred on claims that denied prior to July 1, 1998 and then were denied incorrectly as duplicate when they were resubmitted after July 1, 1998.

Claims that denied before and after July 1, 1998 with a Medical Review/Utilization denial or an MSP denial that had been resubmitted after July 1, 1998 was also denied CO-18. The claims will not be adjusted because they should not have been resubmitted. Please follow the correct adjudication procedure referred above for the initial MR/UR or MSP denial. Please make reference of this information and follow the appropriate procedures.

Did You Know? Clarification

Supplier Notices 98-36 / 98-37
November 30, 1998

Supplier Notice 98-37 is a clarification to Supplier Notice 98-36.

Did you know that you could answer all of the following questions on your computer, in your office, with VPIQ – Claim Status Inquiry:

When will I be paid for Mr. Jones' claim?

What is the status of Mr. Smith's claim?

Is Mrs. King eligible for Medicare Part B? (available only to participating suppliers)

To receive more information on VPIQ-Claim Status Inquiry, visit our web site at www.medicare-link.com or call Team EDI at 717-735-9429. We think you'll be glad you did!

We apologize for any confusion this may have caused.

Important Announcement from Professional Relations

Supplier Notice 98-38
December 4, 1998

Tanya Casaldi has assumed the position of Congressional Liaison, replacing David Fiorini who is now the Orthotics and Prosthetics – CT, MA Ombudsman. Tanya has been with the DMERC for the last two and a half years having served the Customer Service Unit.

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

Please join us in wishing Tanya success in her new assignment.

Inquiries Sent via Internet

Supplier Notice 98-39
December 10, 1998

As Internet usage increases, we have seen that certain confidential beneficiary and provider information is being sent over the Internet.

Providers should *not* include Medicare numbers, Social Security numbers, personal medical information, NSC numbers, or other confidential items regarding the Medicare beneficiary in the e-mail inquiry.

We appreciate your use of the Internet whenever possible, but HCFA requirements preclude its use where any confidential information is involved.

Electric Wheelchair Billing Clarification

Supplier Notice 98-40
December 17, 1998

Effective May 1, 1991:

Suppliers must give beneficiaries the rent/purchase option for an electric wheelchair at the time the item is furnished to the beneficiary.

Effective for claims on or after 1/1/99:

When billing for wheelchair codes K0010, K0011 and K0012, the appropriate "B" modifier *must* be used in the first month of billing to reflect the beneficiary's initial rent or purchase decision.

Billing Examples:

Purchase Option
(first month)

K0010 – NUKHBP
K0011 – NUKHBP
K0012 – NUKHBP

Rental Option
(first month)

K0010 – RRKHBR
K0011 – RRKHBR
K0012 – RRKHBR

The following MCM reference may be presented to the beneficiary to assist with the decision making.

Medicare Payment of Electric Wheelchairs

If you need an electric wheelchair prescribed by your doctor, you may already know that Medicare can help pay for it. Medicare requires all suppliers to give you the option of either renting or purchasing it. If you decide that purchase is more economical, for example, because you will need the electric wheelchair for a long time, Medicare pays 80 percent of the allowed purchase price in a lump sum amount. You are responsible for the 20 percent coinsurance amounts and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. However, you must elect to purchase the electric wheelchair at the time your medical equipment supplier furnishes you with the item. If you elect to rent the electric wheelchair, you are again given the option of purchasing it during your 10th rental month.

If you continue to rent the electric wheelchair for 10 months, Medicare requires the supplier to give you the option of converting your rental agreement to a purchase agreement. This means that if you accept this option, you would own the medical equipment. If you accept the purchase option, Medicare continues making rental payments for your equipment for 3 additional rental months. You are responsible for the 20 percent coinsurance amounts and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. After these additional rental payments are made, title to the equipment is transferred to you. You have until one month from the date the supplier notifies the patient of this option to elect the purchase option. If you decide not to elect the purchase option, Medicare continues making rental payments for an additional 5 rental months, a total of 15 months. After a to-

tal of 15 months have been paid, title to the equipment remains with the medical equipment supplier; however, the supplier may not charge you any additional rental amounts.

In making your decision to rent or purchase the equipment, you should know that for purchased equipment, you are responsible for 20 percent of the service charge each time your equipment is actually serviced and, for unassigned claims, the balance between the Medicare allowed amount and the supplier's charge. However, for equipment that is rented for 15 months, your responsibility for such service is limited to 20 percent coinsurance on a maintenance and servicing fee payable twice per year whether or not the equipment is actually serviced.

CPAP Coverage Criteria

Supplier Notice 98-41 December 18, 1998

The Region A DMERC has received numerous inquiries regarding coverage criteria for Continuous Passive Airway Pressure Systems (CPAPs).

The CPAP Policy states: "CPAP is covered for patients with a diagnosis of obstructive sleep apnea with documentation of at least 30 episodes of *apnea*, each lasting a minimum of 10 seconds, during 6 to 7 hours of recorded sleep. CPAP is covered when used in all adult patients with moderate or severe obstructive sleep apnea, as defined above, for whom surgery is a likely alternative to CPAP."

Reimbursement for CPAP is limited to patients with a diagnosis of obstructive sleep apnea, documented by episodes of apnea. Documented episodes of hypopnea **do not** meet coverage criteria for CPAP. Episodes of hypopnea **should not** be reported in question #12 of DMERC CMN 03.02 for CPAP.

Also, accessories used with CPAP can be billed separately with the NU modifier. If the CPAP and accessories are billed simultaneously and the CPAP is denied, the accessories will also be denied. Furthermore, if the CPAP accessories are billed alone with no record of CPAP in the patient's history, or a denied CPAP in its history, the accessories will be denied.

EDI Extra Documentation Reminder

Supplier Notice 99-01 January 5, 1999

Following is a brief review of the Extra Documentation Policy for electronic claims.

1. CMNs are **NOT** considered extra documentation and will **NOT** be forwarded. They must be submitted at the time the claim is transmitted.
2. Faxes over 10 pages will **NOT** be accepted.
3. Extra documentation must be faxed at least 48 hours prior to transmitting the claim electronically to allow for proper processing.
4. You must indicate in the HA0 record (narrative) the date the documentation was faxed for easier routing.
5. Always use the extra documentation coversheet provided by the Region A DMERC. Copies can be retrieved from the BBS system.

1999 Oxygen Allowable Reduction

Supplier Notice 99-02 January 11, 1999

It has come to the attention of the Region A DMERC that there is some confusion regarding the 1999 Oxygen Equipment Allowable.

According to the 1997 Balanced Budget Act, per HCFA instruction, the oxygen equipment allowable for 1999 will be reduced 5%, in addition to the 1998 reduction of 25%. The 1999 reduction is taken from the 1997 allowable, then added to the 1998 25% reduction to total a 30% reduction. The following is an example of the increased reduction, including the calculation involved in determining it:

Year	Procedure Code	1997 Fee	x %	= Reduction (calculation)	= New Fee
1998	E1400	\$326.87	x .25	= \$81.71 (\$326.87-\$81.71)	= \$245.16
1999	E1400	\$326.87	x .05	= \$16.36 (\$245.16-\$16.36)	= \$228.80

Addition to 1999 Fee Schedule

Supplier Notice 99-03 January 15, 1999

As you are aware, the 1999 fee schedule was not published in the December Newsletter, per HCFA instruction. The following are fees that were not originally listed on the website www.medicare-link.com or on the Bulletin Board System (BBS).

	<u>Ceiling</u>	<u>Floor</u>	<u>Price for each State</u>
A6200	\$9.06	\$7.70	\$9.06
A6201	\$19.84	\$16.86	\$19.84
A6202	\$33.27	\$28.28	\$33.27
A6217	\$0.00	\$0.00	\$.41
L1690	\$1733.81	\$1300.36	\$1420.74
L1847	\$515.70	\$386.77	\$422.57
L3675	\$143.20	\$107.40	\$117.34
L5968	\$3264.55	\$2448.41	\$2675.09
L5975	\$416.48	\$312.36	\$341.28
L5988	\$1794.64	\$1345.98	\$1470.60
L6693	\$2550.44	\$1912.83	\$2089.92
L8015	\$50.96	\$38.22	\$41.75

There are still no fees listed for the following:

A4321	-	-	This code is denied
A4483NU	-	-	-
A4483UE	-	-	-
E0785 NU, RR, UE	-	-	-

A Supplier Notice will be issued upon receiving those fees.

A complete hard copy of the fee schedule can be ordered by sending a check in the amount of \$15.00 payable to United HealthCare. Refer to the 1999 Fee Schedule order form at the end of this newsletter.

1999 Ceiling Fees for Therapeutic Shoes

Supplier Notice 99-04 January 28, 1999

This is to inform the supplier community of the 1999 Special Limitation for Therapeutic Shoes under the Standard Reasonable Charge Rules. These limits apply to codes **A5500 – A5506**. Reasonable charge fees are established for each state. However, the maximum allowable amount for each code cannot exceed the ceiling amount. The current ceiling breakdown for 1999, which is the same for all states, is as follows:

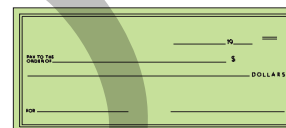


<u>Code</u>	<u>Ceiling</u>	<u>Code</u>	<u>Ceiling</u>
A5500	\$63.00	A5504	\$32.00
A5501	\$189.00	A5505	\$32.00
A5502	\$32.00	A5506	\$32.00
A5503	\$32.00		

Miscellaneous Check Issuances

Supplier Notice 99-05 February 10, 1999

The region A DMERC may issue payments to providers which are not the direct result of claims processing. These payments are dispensed as miscellaneous checks. Some instances of this practice are: replacement checks, fair hearing reversals and supplier corrections.



Effective immediately, the Region A DMERC will no longer issue miscellaneous checks to providers with any outstanding overpayment greater than 40 days. Rather, these checks will be applied to the oldest uncollected overpayment currently in our system. This process will continue until each outstanding overpayment is satisfied. Suppliers must continue to refund any overpayment request within 30 days to avoid interest and collection activity.

Any supplier affected by this process will be notified in writing by the DMERC.

Billing Requirements for Primary and Secondary Ventilators

Supplier Notice 99-06 February 16, 1999

The Region A DMERC has become aware of concerns from the supplier community regarding the correct billing procedure for a primary ventilator and a secondary ventilator.

When billing the Region A DMERC for both a primary ventilator and a secondary ventilator, please bill both ventilators for the same date of service on the same claim, with the primary and secondary ventilator on a separate claim line in order to assure proper claim adjudication.

Example:	<u>DOS</u>	<u>Proc. Code</u>	<u>Sub. Charge</u>	<u># of Units</u>
	1/1/99	E0450RR	\$1000.00	1
	1/1/99	*E0450RR	\$1000.00	1

*The use of miscellaneous procedure code E1399 for the secondary ventilator is incorrect and will be denied.

The following are examples of situations in which a patient would qualify for both a primary ventilator and a secondary ventilator

1. A patient requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g. positive pressure ventilator with a nasal mask) during the rest of the day.
2. A patient who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without two pieces of equipment the patient may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

In either scenario, this additional information must be relayed to the DMERC with each claim submission for both a primary and secondary ventilator.

1999 Fee Schedule Updates/ Revisions

The following are immediate updates and revisions to the Region A DMERC 1999 fee schedule:

Code	A4265	E0147NU	E0147RR	E0147UE	L1843
CT	3.23	548.27	54.82	411.22	659.23
DE	3.23	548.27	54.82	411.22	659.23
MA	3.23	548.27	54.82	411.22	659.23
ME	3.23	548.27	54.82	411.22	659.23
NH	3.23	548.27	54.82	411.22	659.23
NJ	3.23	548.27	54.82	411.22	659.23
NY	3.23	548.27	54.82	411.22	659.23
PA	3.23	548.27	54.82	411.22	659.23
RI	3.23	548.27	54.82	411.22	659.23
VT	3.23	548.27	54.82	411.22	659.23

Per HCFA, effective April 1, 1999, code A4265's (paraffin, per pound) payment category will be changed to a fee schedule item.

Certificate of Medical Necessity

CMN Audit Documentation Requirements

During recent audits of Certificates of Medical Necessity (CMNs) the following documentation errors were noted:

- Section C should contain only fee and charge data for items ordered by the physician. Medical information regarding beneficiaries should not be entered in Section C.
- Discrepancies were found between electronically submitted (EMC) certificates of medical necessity and the original signed CMNs submitted for review. Discrepancies that did not match included:
 - initial/revision dates
 - physician signature dates
 - diagnosis codes
 - length of need
 - question set answers

CMNs transmitted via EMC should have the same information that is on the original signed document received from the physician.

Suppliers should refer to their supplier manual for information regarding the proper completion of all CMNs.

CMN Rejects and Concurrent Claim Submission

Even though a CMN may be rejected through EDI as a result of hitting a front-end edit, the claim does not reject from the system, just the CMN. If a CMN has been rejected and there are other CMNs on file, the claim will pay or deny based on the most current CMN we have on file. The above is the primary reason why 1) CMNs should be filled out accurately i.e., initial, revised, and recert dates, medical necessity length etc., and 2) CMNs should be sent in chronological order. For example, if a claim is submitted and includes a CMN which has a "revised date" which is less than a revised date already on the system, the CMN will reject, but the claim will pay or deny off of the most current CMN in the system. This has the potential to result in both overpayments and underpayments.

When a CMN is rejected from the system due to a "back-billing" situation, there are two options for having the CMN added to the system:

- Include a copy of the CMN with the documentation sent in for review
- The rejected CMN must be submitted hard copy with a claim to be manually added to the system.

X-Modem Protocol

Suppliers using X-Modem Protocol to download various files may experience problems processing these files for reports, or may not retrieve a complete file. We suggest you use one of the following protocols: Kermit, Superkermit, Y-Modem, Sealink, or Z-Modem.

Submitting Correct ICD-9 Codes Reminder

When submitting claims electronically, be sure to correctly enter any ICD-9 codes that consist of four-digits as five-digit ICD-9 codes, adding a zero to the front. For example:

Diagnosis code 85.41 must be submitted on an EDI claim as 085.41. If not submitted this way, it will be read as 854.1.

Electronic Fund Transfer

Electronic Fund Transfer (EFT) is a long established technology that is widely used because it is more reliable and less expensive than mailing paper checks. Paper checks travel through the mail, and need to be clerically processed in your office, deposited, and then cleared by the bank.

On the other hand, with EFT, Medicare determines the amount that needs to be paid on your claim and electronically notifies Citibank of the amount. At this point, Citibank sends the payment to your bank, which in turn, deposits the funds into your account, whether it is a checking or savings account. With EFT there is:

- No US Mail involved
- No deposit forms to fill out and balance
- No trips to the bank to make deposits
- No waiting period for the checks to clear before the funds are available

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 Regions 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	800-470-9630
Region C	803-788-0222
Region D	208-333-2141

BBS Toll Free Line Termination

Effective October 1 1998, HCFA Estopped funding toll-free EDI transmission lines for participating physicians and suppliers. On January 1, 1999, the Region A DMERC discontinued the use of toll-free EDI lines for claim submission to our BBS. All electronic submitters will now dial our current toll BBS number of 570-735-9515.

Important EDI Numbers

Bulletin Board

Production BBS: **570-735-9515**
ERN BBS: **570-735-9451**

EDI Help Desk

570-735-9429

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.

EDI Enrollment Form

The Region A DMERC requires a complete EDI Enrollment Form for each NSC/Provider number that is billed electronically. To receive a copy of an EDI Enrollment Form, visit our web page at www.medicare-link.com or contact Team EDI at 570-735-9429. If you receive a BA00205 edit message on your reject report, we need a new EDI Enrollment Form for that NSC/Provider number.

Accelerate Updates Available on the BBS

Any updates that are made to the Accelerate software are available to download via the BBS. Log on as you normally do and access the main menu. Choose menu option "G," then menu option "A." The file name you need to download will be "update.exe." The current build number of Accelerate that you are using is located on the date verification screen, top right corner. If that build number is lower than the build number listed in the update files description, you need to download the latest update. Once you've downloaded this file, access your medbdme prompt in DOS, type "update" and answer yes to each file you are prompted to overwrite.

Accelerate Software Commonly Asked Questions

1. **I am entering a claim on the claim screen. When I press the F3 key, I get a message that the NPI number is required after 01011999.**

A minor change to the software is required. You may contact the EDI Help Desk for faxed instructions or a walk-through. You may also download the latest update to Accelerate from the Bulletin Board System (BBS).

2. **I am unable to connect to the BBS.**

Make sure you are dialing 570-735-9515. This is the only number available for the BBS.

3. **I am from New Jersey (or New York) and am having a problem connecting to your BBS with the 570-735-9515 number.**

Currently, the new 570 area code does not function in New York or New Jersey. You will need to contact your phone company to find out when this area code will be available in your area. In the interim, you will need to use the 717 area code.

4. **When I try to dial, I get a message "no dial tone" or "no carrier."**

This message will be activated only when your modem attempts to dial out of your office and there is no dial tone. Check the following possibilities:

- Check to make sure you are not dialing on the same line you are talking on.
- Make sure your phone line is connected to the line jack of the modem.

- If your modem and fax machine share the same line, make sure the fax machine is not in use, or turn the fax machine off before trying to dial.
- If you have an external modem, make sure it is turned on.
- Make sure the modem line is plugged into the wall jack.
- Unplug the phone line from the back of the modem and plug it into a phone. Listen for a dial tone. If you do not have a dial tone, you need to contact your phone company to check the line.

5. **Procomm or BananaCom will not dial or find my modem.**

The communication software is probably not set up for the Com Port and/or IRQ that your modem is using in your PC. You need to contact the modem manufacturer or the person that installed your modem to find out what Com Port and IRQ your modem requires.

Or, you may have a Plug and Play modem or Winmodem (software modem). These modems require Windows 95 or 98 to function; they will not function in DOS. You can contact the EDI Help Desk for a courtesy copy of HyperTerminal instructions, communication software that is included with Windows 95 and 98.

6. **My submitter number disappeared from the submitter information screen.**

Go to a c:\medbdme prompt and type RESTSUB, and then press the enter key.

7. **My claims are rejecting on the reject report with a BA00205 edit.**

This occurs when we do not have a current EDI Enrollment Form on file for the NSC number being billed. For a copy of the EDI Enrollment Form,

contact the EDI Help Desk or download one from our web page.

8. **I need to check the status on my claims and cannot reach Provider Services.**

Contact the EDI Help Desk or visit our web page for information on VPIQ.

From reviewing our BBS activity logs, we find that many submitters, once connected to our BBS, do nothing more and are disconnected after the two-minute inactivity time limit. It appears they do not initiate a file transfer using the instructions found on pages 46 through 49 of the *Accelerate Manual*. Submitters should expect to be disconnected after two minutes of inactivity.

The message "Transfer Successful" does not necessarily mean we have received a processable file. The common front end may not accept the file, even if the data transfer was successful on the BBS. Submitters must download their reject report for confirmation of receipt of file. If submitters believe they sent a file and do not have a reject report the following day, they must retransmit the file.

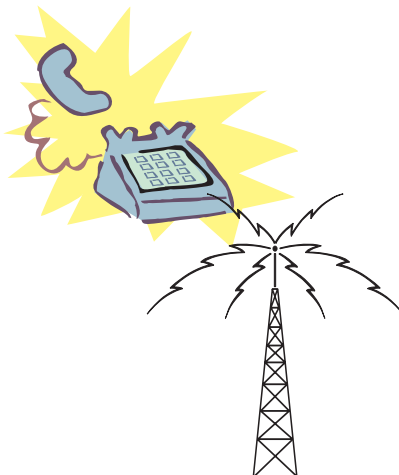
Approximately 20% of Help Desk issues include failure to pull reject reports. This report is the submitter's only advice of the results of the transmission. Refer to page 60 of the *Accelerate Manual* for instructions.

New Claim Status Inquiry System

With our conversion to the new VMS system, we have converted 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 date of service or HICN 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 to receive an addendum for you to authorize the setup of these options.

Multiple File Transmissions

When transmitting claims to the Region A DMERC, if you have more than one file to transmit, you must hang up in between each transmission. If you neglect to do this, your files will be overwritten with each subsequent file.



Cut Your Transmission Time

The Region A DMERC BBS can accept production files that are submitted in a zipped file format. This allows for multiple files to be sent at once and reduces your transmission time. If you are interested in this option, you must contact Team EDI to have your BBS account modified to receive zipped files. Once your account is set up for zipped files, you can send only zipped files.

For information about zip software, you can visit www.pkware.com or www.winzip.com. Contact your vendor to see if their software supports sending zipped files.

Guidelines for zipping files:

You are not limited to the number of files you enclose within the zipped file.

The name of the files within the zipped file must use the following standards:

1. The first character must be the letter of your submitter ID.
2. The next four characters must be the last four digits of your submitter number.
3. The last three characters are a sequence number beginning with 001.
4. The file extension must be .dat

Example: If your submitter number is A09080706 and this is the third file you are adding to the zip file, the name of the file is a0706003.dat. If your submitter number is B08839909 and this is the first file being zipped, the file name is b9909001.dat

The name of the zip file being transmitted does not matter as it will be renamed upon receipt.

Team EDI
(570) 735-9429

Important Information Concerning Accelerate and its' Communication® Software

The Year 2000 (Y2K) or millennium change will affect everyone in varying ways. One area of concern is the communications software used to transmit your claims to, and receive various outputs from, United HealthCare.

The Health Care Financing Administration now requires that Medicare software be Y2K certified. The DOS shareware versions of Procomm® and BananaCom that we previously distributed with our Accelerate claim entry system have not been certified to our satisfaction. Therefore, United HealthCare will no longer distribute these versions of communication software.

We will be offering for sale, at a considerable discount, a Y2K certified version of Procomm® called Procomm® Connections. Procomm® Connections will operate under Windows 95®, Windows 98®, or Windows NT®. We will also provide a version of DOS Accelerate that will automatically interface with Procomm® Connections to initiate file transfers.

In addition to Y2K certification, other advantages of Procomm® Connections include:

1. Once your modem is set up in Windows, Procomm® Connections will use the Windows setup; i.e., you should not have to set up your modem in Procomm® Connections.
2. Procomm® Connections will use the full speed of your modem. You will no longer be limited to 9600 baud.
3. The default protocol is ZMODEM, which is faster and more reliable than YMODEM.
4. Procomm® Connections will work with Winmodems (not possible with DOS Procomm®).
5. If submitters are having memory problems trying to run Procomm® through Accelerate, Procomm® Connections will alleviate this, as it runs in Windows and does not use DOS memory.

For submitters using Windows 3.1®, United HealthCare will be offering for sale a version called Procomm Plus®. Procomm Plus® will NOT interface automatically with Accelerate and submitters will need to manually initiate file transfers.

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P.O. Box 6800
Wilkes-Barre, PA 18773-6800
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Submitters, who do not wish to purchase Procomm® Connections or Procomm Plus® from United HealthCare, will be able to use their own communications software.

- ♦ One option is HyperTerminal, available at no cost for users of Windows 95®, Windows 98®, and Windows NT®. Terminal is available at no cost for users of Windows 3.1®. HyperTerminal and Terminal uploads and downloads will have to be performed manually.
- ♦ Another option for Windows 95®, Windows 98®, and Windows NT® is a more robust version of Procomm® called Procomm® Plus 32. Our new version of Accelerate will interface automatically with Procomm® Plus 32.

We do not recommend continued use of the DOS shareware version of Procomm® or BananaCom to exchange data with United HealthCare. After April 30, 1999, United HealthCare will not provide assistance or be responsible for any Year 2000 problems associated with the use of these products.

Through an arrangement with Symantec Corporation, the company that produces Procomm®, United HealthCare will offer copies of Procomm® Connections and Procomm® Plus to our submitters at a price of \$60. Included in this cost are free upgrades and technical support for one year. This is significantly lower than the list price of \$100 - \$129. If you are interested in purchasing this software from United HealthCare, complete and return the attached Software Identification Form. For further information, please contact our EDI support area at (570) 735-9429.

Because of the upcoming changes to the Procomm® communications portion of the Accelerate package, United HealthCare requires specific information to ensure that necessary technical assistance can be provided to you, if needed. Therefore, please complete and return the attached "Accelerate and Procomm® Software Identification Form" to United HealthCare no later than 14 days after receipt of this notice. Mail the completed form to:

United HealthCare Insurance Company
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: EDI/Procomm

Notes:

Procomm®, Procomm® Plus, Procomm® Connections, and Procomm® Plus 32 are registered trademarks of Symantec Corporation and its subsidiaries (DATASTORM Technologies, Inc., a subsidiary of Symantec Corporation)

HyperTerminal is a product of Hilgraeve, Inc.

United HealthCare does not endorse HyperTerminal or any Procomm® software, including Procomm®, Procomm® Connections, Procomm® Plus, or Procomm® Plus 32.



Team EDI
(570) 735-9429

Accelerate and Procomm® Software Identification Form

Because of the upcoming changes to the Procomm® communications portion of the Accelerate package, United HealthCare requires specific information to ensure necessary technical assistance can be provided to you, if needed. Please complete and return the attached form to United HealthCare no later than 14 days after receipt of this notice.

Name _____

Address _____

City _____ State _____ Zip _____

Contact Name _____

Telephone Number _____

Submitter Number (**Required**) _____

1. Please place a check mark next to the version of Windows that you will be using:

☐ Windows 3.1 ☐ Windows 95 ☐ Windows 98 ☐ Windows NT

2. Please place a check mark next to the communication software you will be using:

☐ Procomm® Plus - Available through Government Operations of United HealthCare. Minimum system requirements for Procomm® Plus are

- 386-enhanced mode or better running Windows 3.1
- VGA or better video display
- CD-ROM drive for installation
- 4 MB RAM (8 MB recommended)
- 35 MB disk space for full installation
- Mouse recommended



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MEDICARE Part B Carrier

Accelerate and Procomm® Software Identification Form

Page 2

- ☐ Procomm® Connections - Available through Government Operations of United HealthCare. Minimum system requirements for Procomm® Connections are

- Intel compatible PC running Windows 95/98 or NT 4.0
- VGA or better video display
- CD-ROM drive for installation
- 8 MB RAM for Windows 95/98 (16 MB recommended)
- 16 MB RAM for Windows NT 4.0 (32 MB recommended)
- 25 MB disk space for full installation

- ☐ Procomm® Plus 32 - Works with the new Accelerate version, but is not available through Government Operations of United HealthCare.

- ☐ Other (please specify)

3. Are you purchasing Procomm® from Government Operations of United HealthCare?

☐ Yes

☐ No

4. What are you purchasing?

☐ Procomm® Plus
CD-ROM

☐ Procomm® Connections
CD-ROM

5. Is your check (payable to United HealthCare) for \$60.00 enclosed?

☐ Yes

☐ No

If you have questions about this questionnaire, please call us at (570) 735-9429:

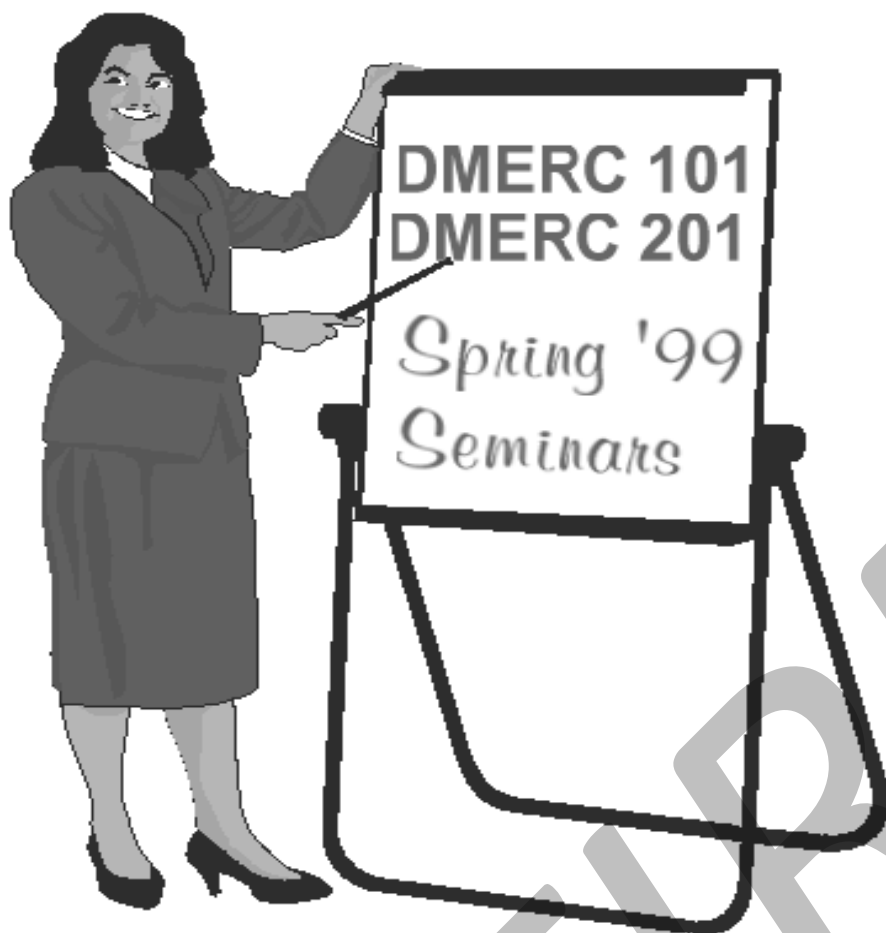
We appreciate your taking the time to complete this form. Please mail the completed form and check, if applicable:

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

Attn: EDI/Procomm

Thank you,

Team EDI



The Region A DMERC announces its Spring '99 seminar schedule. This Spring we will be offering two seminars; DMERC 101 and DMERC 201. DMERC 101 is geared towards the new biller, and DMERC 201 is for the experienced biller. Topics to be covered in DMERC 101 are: HCFA-1500, Certificates of Medical Necessity (CMNs), Fraud and Abuse, and a DMERC update. DMERC 201 will cover updates on the following: VIPs, HCFA, Medical Policy, and introducing "Life of an Appeal."

April 12

Boston Marriott Newton
2345 Commonwealth Avenue
Newton, MA 02166
617-969-1004

April 14

Holiday Inn by the Bay
88 Spring St.
Portland ME 04101
207-775-2311

April 16

Tara Wayfarer Inn
121 South River Road
Bedford, NH 03110
603-622-3766

April 19

Wyndham Garden LaGuardia
100-15 Ditmars Blvd.
East Elmhurst, NY 11369
718-426-1500

April 20

Ramada Inn Conference Ctr
379 Monmouth St. Exit 8 NJ Tpk
East Windsor, NJ 08520
609-443-8000

April 27

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

April 30

Buffalo Marriott Amhearth
1340 Millersport Hwy.
Amhearth, NY 14221
716-689-6900

May 3

Wyndham Garden Airport
One Wyndham Circle
Pittsburgh, PA 15275
412-695-0002

May 5

Philadelphia Airport Marriott
Arrivals Rd
Philadelphia Int'l Airport
Philadelphia, PA 19153
215-492-9000

May 7

Ramada Plaza Hotel
20 Public Square
Wilkes-Barre, PA 18701
570-824-7100

May 11

Hilton Downtown Hartford Hotel
315 Trumbull Street
Hartford, CT 06103
860-240-7324

May 13

Resorts International Casino
1133 Boardwalk & North Carolina Ave.
Atlantic City, NJ 08401
609-344-6000

Registrations must be received by the DMERC **five business days** prior to the date of the seminar you wish to attend. Any registration received after that date will not be accepted and will be returned to the supplier. Please allow adequate time for mailing.

Mailing Address

Regular Mail

Attn. Seminar Registration
United HealthCare
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

Overnight Mail

Attn. Seminar Registration
United HealthCare
Region A DMERC
60 East Main Street
Nanticoke, PA 18634

The DMERC reserves the right to cancel any seminar. If this occurs, you will be notified and your registration fee will be refunded.

Confirmation will be sent within 48 hours of receipt.

Parking Information

When reserving seminar facilities, we do our best to choose locations with ample, free parking. Unfortunately, cost-free parking is not always available. Please phone the meeting facility for specific information regarding location and possible parking fees

✂ _____

Registration Form

Please complete a registration form for each person attending.

Company _____

Provider Number _____ Submitter Number (Billing Services Only) _____

Address _____

Phone _____ Fax _____

Location of Workshop _____

Amount Enclosed _____

Name of Attendee _____

Contact Name _____

Please check the appropriate box(es) to indicate which workshop(s) you wish to attend.

AM Session 9:00 AM - 12:00 PM

☐ DMERC 101 – Basic Billing

PM Session 1:30 PM - 4:30 PM

☐ DMERC 201 – Advanced Billing

1999 Fee Schedule



The Region A DMERC will not be providing complimentary copies of the 1999 fee schedule, per HCFA instruction. You may access the fee schedule data on our bulletin board or website at www.medicare-link.com.

The cost for the hardcopy is \$15.00

If you would like a copy, complete the following form and make checks payable to United HealthCare at:

United HealthCare
Attention: Professional Relations
P.O. Box 6800
Wilkes-Barre, PA 18773

Company _____ Provider Number _____
Contact Name _____ Address _____
Phone _____ Fax _____ Number of copies _____ Amount Enclosed _____

DMERC Medicare News

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