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
Number 45 •September, 1999

Region A DMERC Fall 1999 Seminars
Y2K / EDI

Mark your calendars - the fall 1999 Region A DMERC seminar schedule is set!
These seminars will focus on preparing for the year 2000 and answering your EDI questions.

Seminar Date	Location and Phone	Registration Deadline
Thursday, October 7	Pittsburgh, PA Pittsburgh Marriott City Center, 112 Washington Place Phone: 412-471-4000	September 27
Monday, October 11	Milford, MA Radisson Hotel Milford, 11 Beaver Street Phone: 508-478-7010	September 30
Monday, October 18	East Elmhurst, NY LaGuardia Marriott, 102-05 Ditmars Boulevard Phone: 718-565-8900	October 4
Wednesday, October 20	King of Prussia, PA Holiday Inn Valley Forge, 260 Mall Boulevard Phone: 610-265-7500	October 8
Monday, October 25	Portland, ME Sheraton South Hotel, 363 Maine Mall Road Phone: 207-775-6161	October 14

Agenda

12:30 – 1:00 P.M.	Registration	3:00 – 3:15 P.M.	Break
1:00 – 3:00 P.M.	Y2K What is Y2K? DMERC Testing & Planning HCFA Y2K Update Y2K Resources/Readiness	3:15 – 4:30 P.M.	EDI EDI & Y2K CMN Reject Reports EDI Audits Questions & Answers

Registration information is found on page 3

HCFA Health Care Financing Administration

UNITEDhealthcare®

In This Issue

Internet Address

Region A DMERC Office
www.medicare-link.com

HCFA Office
www.hcfa.gov

DMERC Region A Contacts

United HealthCare Region A DMERC	(570) 735-9400
United HealthCare Region A DMERC Fax	(570) 735-9402
Accounting	(570) 740-9002
Accounting / MSP Fax	(570) 735-9594
Beneficiary Help Line	(570) 735-7383
Beneficiary Toll Free Help Line	(800) 842-2052
EDI Fax	(570) 735-9510
EDI Help Desk	(570) 735-9429
Hearings Fax	(570) 735-9422
Hearings Voice Mail	(570) 735-9513
Medicare Secondary Payer (MSP)	(570) 735-9001
National Supplier Clearinghouse	(803) 754-3951
Professional Relations Fax	(570) 735-9442
Professional Relations	(570) 735-9666
Program Integrity Toll Free Line	(888) 697-7849
Reconsiderations Fax	(570) 735-9599
SADMERC	(803) 736-6809
Supplier Help Line	(570) 735-9445

How to Register

Please note - There is **no** registration fee for these seminars.

Complete the registration form and fax or mail to the appropriate address as noted below. **All attendees must be pre-registered. Due to limited space, registration is on a first come, first served basis.** In the event that a particular seminar is filled to capacity, you will be notified by telephone.

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Parking information

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

Once registration is complete, no changes will be made. Please make your selection very carefully.

Please do not contact the hotel for seminar information.

Please complete and then mail or fax your Fall 1999 Seminar Registration Form to:

Seminar Fax Number: (570) 735-9442 Attn: Seminar Registration

Mailing Addresses:

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 18634-1685

The DMERC reserves the right to cancel any seminar. If this occurs, you will be notified by telephone.

Note: *If you do not receive your confirmation within 5 days of the seminar you have registered for, please call our Professional Relations Unit at 570-735-9406.*

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Fall 1999 Seminar Registration Form

Company

Provider Number

Address

Phone

Fax

Location of Seminar

Name of Attendee

Contact Name

Biomedical Equipment Year 2000 (Y2K) Compliance

The Department of Veterans Affairs (VA) and the Department of Health and Human Services (HHS) have established an on-line database to provide health care providers and their patients with timely information about the potential impact of the Y2K data change on specific biomedical equipment.

The database provides timely, easily obtained information about medical devices that health care practitioners, medical treatment facilities, and consumers may use and / or manage. It is designed to provide much needed information and to help ensure patient health and safety.

Under an interagency agreement, the VA and HHS have designated the Federal Y2K Biomedical Clearinghouse as an on-line database on an Internet website operated and maintained by the Food and Drug Administration (FDA). The website address is:

http://www.fda.gov/cdrh/yr2000/year2000.html

Data included in the clearinghouse are restricted to publicly releasable information provided directly by manufacturers to the members of the clearinghouse.

There are approximately 13,000 medical device manufacturers. The database identifies equipment unaffected by the date change and lists equipment with problems ranging from display of an incorrect date to expected device failure on January 1, 2000.

Year 2000 Testing via the Bulletin Board System

As of July 1, 1999, electronic claim vendors and providers may begin testing on our asynchronous Bulletin Board System (TBBS). The purpose of our Year 2000 (Y2K) testing is to confirm the successful transfer of claim data with future dates between your billing system and our Medicare claim collection facility. Although this testing does not certify your system for Y2K compliance, our Y2K test will show what will happen with claims created by your renovated billing system. You'll also find more information about Y2K on our website at **www.medicare-link.com/y2k/contents.htm**. We strongly encourage you to test your system after it has been renovated for Y2K.

To submit Y2K test claims, please follow the steps listed below.

1. Complete and fax or mail the attached questionnaire to the Region A DMERC EDI department. After the EDI department establishes your testing setup, you will be notified when you can send your initial test file.
2. Our Y2K test system telephone number will be supplied upon initial testing. The test system will be available July 1, 1999 until January 20, 2000. Our test system will be set at the current date plus 364 days, (e.g., July 7, 1999 will be processed as July 5, 2000).
3. When you access the system for the first time, use the word "new" for the initial logon password. As part of the logon process, reset your password. The test file you create should contain between 15 to 30 claims.
4. We suggest that you include the following dates in your test: 12 / 31 / 1999, 01 / 01 / 2000, leap-year 02 / 28 / 2000, 02 / 29 / 2000, and 03 / 01 / 2000.
5. Files submitted by 4:00 P.M. on any business day will be processed by noon the next business day. Please remember to download and review your Reject Report.

If you have any questions, please contact the EDI Department at (570) 735-9429.

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Y2K Testing Questionnaire

Company Name: _____

Current Submitter Number: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ FAX: _____

Type of Format: NSF Version: ____ ANSI Version: _____

Mail to: DMERC Region A
United HealthCare Ins. Co.
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: EDI

or Fax: 570-735-9510

Once you begin testing, please make sure you send your test claims to the number provided on the fax.

Submitting, Processing, and Paying Medicare Claims in the Year 2000

The Implementation of Provider Payment Updates and Related Issues

> "*HCFA's top priority between now and January 1, 2000, is to make sure that Medicare computer systems are Y2K compliant so that Medicare beneficiaries' care is uninterrupted and that providers' claims are paid in a timely fashion. At the same time, HCFA wants to meet statutory deadlines for making routine payment updates for providers, and I'm please that we're now on track to meet both goals.*"
>
> Nancy-Ann DeParle,
> HCFA Administrator

Because of its significant progress in preparing for systems challenges in the year 2000 (Y2K), the Health Care Financing Administration (HCFA) and United HealthCare Insurance Company anticipate the timely and accurate processing of Medicare claims to continue into the new millennium, including provider, supplier, and other payment updates. The following article summarizes HCFA's Y2K activities, delineates the schedule for implementation of provider payment and other annual updates, and instructs you, as Medicare providers and suppliers, how to handle and expedite the processing of your claims during the century rollover.

Summary of Y2K Activities

Following the recommendation of its Y2K expert consultant (know as an independent verification and validations (IV&V) contractor), HCFA announced last summer that provider payment updates might have to be delayed to minimize computer system changes during final Y2K testing and monitoring. However, after reviewing the status of the renovation and testing of systems with its IV&V contractor, HCFA has determined that the substantial progress made on Y2K preparations should allow provider payment updates to occur in a timely manner. In the words of Ms. DeParle: "We've made excellent progress on Y2K readiness, and our success means we can make the provider payment updates without jeopardizing our systems."

Throughout the fall, United HealthCare and HCFA will continue to test and retest their computer systems. All HCFA and United HealthCare systems will undergo an extensive recertification process.

Schedules for the Implementation of Provider Payment and Other Updates

Statutory Requirements. By law, Medicare payment rate updates for Part A providers, including inpatient hospitals, skilled-nursing facilities, home-health agencies and hospices, are to occur on October 1 of each year, except for the payment rate update for swing bed hospitals, which is to occur on January 1 of each year. Payment rate updates for physicians and other Part B providers and suppliers are to occur on January 1 of each year.

Part A Provider Payment Updates. HCFA plans to make October statutory Part A payment updates on October 1, 1999. The statutory swing bed hospital payment rate update will be handled as for other January annual updates, a process described below.

No Changes to ICD-9-CM Codes. To minimize system complexity at this critical time for Y2K testing, there will be no changes in ICD-9CM codes (International Classification of Diseases, 9th Revision, Clinical Modification) for fiscal year 2000.

Part B Provider Payment and Other January Annual Updates. HCFA plans to make Part B provider/supplier payment and other January annual updates on January 17, 2000, but will apply the updates retroactively to all claims for services provided on or after January 1. HCFA is waiting until January 17 to make this change to reduce the risk of system problems impacting the year 2000 rollover. The updates which will be put into production are listed below:

Updates to be in Production January 17, 2000

- All Part A and Part B Coinsurance and Deductible Amounts
- Clinical Diagnostic Laboratory Fee Schedule
- Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule
- HCFA Common Procedure Coding System (HCPCS) *
- Inherent Reasonableness
- Medicare Physician Fee Schedule
- Reasonable Charge (Ambulance Services, Certain DME Supplies, Blood Supplies/Transfusion Medicine)
- Rural Health Clinic/Federally Qualified Health Center Annual Upper Payment Limit
- Screening Mammography Limit
- Swing Bed Rate

* We will be sending you more information later regarding the use of CPT and HCPCS codes in the year 2000.

Submitting and Processing Claims in the Year 2000

Claims With Year 2000 Service Dates. Beginning January 1, 2000, you may file claims as usual, but Medicare contractors will hold all claims with dates of service of January 1 or later until January 17 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. Beginning on January 17, 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 until January 17 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. From January 1 until 17, claims having dates of service only occurring during the calendar year 1999 or a previous year will continue to be processed and paid using appropriate payment rates. However, because of the way our system functions, any claim received from January 1 until January 17, 2000, that includes services occurring during calendar year 2000 and previous years will be held in its entirety until January 17. If you have a claim with dates of service occurring in both 2000 and in a previous year, and you do not wish the entire claim held until January 17, 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.

Using CPT and HCPCS Codes in the Year 2000. We will be sending you more information in the future regarding the use of CPT and HCPCS codes in the year 2000.

For More Information

Please feel free to contact us for more information about this article or about Y2K issues in general at telephone number 570-735-9445 or visit our Website at www.medicare-link.com. For Y2K questions and concerns, you may also contact either of the following:

The HCFA Y2K Outreach Line at:
1-800-958-HCFA (4232)

The HCFA Y2K Website at:
WWW.HCFA.GOV/Y2K

New Medicare Options

The U.S. Congress passed a law in 1997 called the Balance Budget Act. This law includes a section called Medicare + Choice, which allows new Medicare health plan options. Most of these new options, however, may not be available yet in your area. Your customers may ask you questions about the new options based on information they read or heard from their friends. You can help your customers by telling them that there are several resources available to them to go to for information. Some of these resources are listed below:

1-800-MEDICAR(E)

Established by the Health Care Financing Administration (HCFA), the new Medicare + Choice toll-free line is now available throughout the United States.

"This new nationwide phone line gives Medicare beneficiaries across the country one more tool to get help with their questions about Medicare and their Medicare health plan options," said Health and Human Services Secretary Donna E. Shalala. "This is a key part of our education campaign to ensure that beneficiaries get accurate and unbiased information about their Medicare benefits, rights and options."

Callers to **1-800-MEDICAR(E) (1-800-633-4227)** can talk to a customer service representative in English or Spanish between 8 A.M. and 4:30 P.M. local time, Monday through Friday to get:

- general information about Medicare;
- general information about Medicare health plan options in their community, including original fee-for-service Medicare and, where available, managed care;
- specific quality and satisfaction information about managed care plans;
- general information about Medicare supplemental insurance (Medigap); and
- telephone numbers for help with a variety of related issues, such as billing questions about Medicare claims or for help with more complex questions about health insurance.

The toll-free telephone line is open 24 hours a day, seven days a week. During non-business hours, callers can access an automated line to:

- request Medicare & You handbooks or audio tapes in English or Spanish,
- request updated information about health plans available in their areas,
- listen to pre-recorded answers to other frequently asked questions.

Callers with access to a teletypewriter (TTY) or telecommunications device for the deaf (TDD), can call 1-877-486-2048.

WWW.MEDICARE.GOV

The official U.S. Government website for Medicare information established by the Health Care Financing Administration is WWW.MEDICARE.GOV. This site has useful information for Medicare beneficiaries and those involved in helping with their health care decisions. The main topics are:

- *What is Medicare?*: Medicare information, including eligibility and enrollment, and how to read a Medicare Summary Notice.
- *Medicare Health Plans*: Medicare health plan options and educational materials. (Visitors can access "Medicare Compare" from this page to get information about health plans in their area.)

- *Who to Contact:* Information by State on the organizations that can help answer Medicare-related questions.
- *Publications*: Medicare publications in English and Spanish available to view, download, and print.
- *Wellness*: Information on Medicare prevention benefits to help keep you healthy, and facts about health issues such as peptic ulcers and pneumonia.
- *Fraud and Abuse*: How to identify and avoid common abuses of Medicare.
- *Nursing Homes*: Payment, patient rights, and nursing home survey results.

Medicare & You 2000

The Health Care Financing Administration will publish the Medicare & You 2000 handbook which will provide basic information that is accurate to Medicare beneficiaries in an easy to read format with clear referrals for more detailed information using English, Spanish, audiotapes and Braille. The handbook will be delivered to all current Medicare beneficiaries by October 15, 1999.

Medicare & You 2000 is HCFA's primary Medicare publication. The Balanced Budget Act of 1997 mandates that general and plan comparison information be mailed to all current Medicare beneficiaries by October 15 of each year, beginning in 1999.

Medicare + Choice Video

A 15-minute video presentation on Medicare + Choice has been produced by the Health Care Financing Administration Philadelphia Regional Office. If your office has a VCR in your customer waiting area and you would like a free copy of this video, please contact Monique Clayton at (215) 861-4508.

The Customer Service Team

The Customer Service Team would like to make your experience with Medicare both efficient and educational. In our continued efforts to provide exceptional customer service, the Customer Service Team identifies the most commonly asked questions and answers and publishes them in our quarterly newsletter.

We will also publish any related Supplier Notices or Alerts, previously published DMERC newsletter articles, or website information relevant to your questions. This information can be used by you, our valued customer, to have your claims properly adjudicated.

- Please remember that based on provisions of the Privacy Act of 1974, the Region A DMERC cannot release any information regarding Medicare eligibility, enrollment, or coverage dates of a specific beneficiary to a Medicare Supplier. If you have a question regarding this information, please contact the beneficiary directly. Additionally, if the beneficiary requires further clarification or assistance, he or she should contact the Social Security Administration at 1-800-772-1213.

Our Customer Service Team receives many inquiries regarding mailing addresses for our Review and Adjustment Departments. In addition to these inquiries, we also receive requests asking us what type of denials should be submitted for review or adjustment. Please refer to Supplier Notice 98-35, "Tips for Adjudicating Claims."

The address for the Review Department is:

United HealthCare Ins. Co.
Attn: Review Department
Region A DMERC
P.O. Box 6300
Wilkes-Barre, PA 18773-6300

The address for the Adjustment Department is:

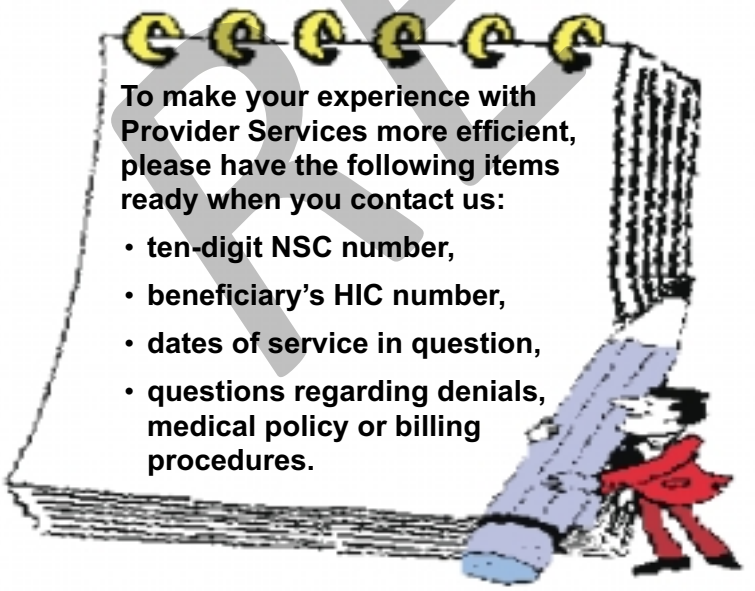
United HealthCare Ins. Co.
Attn: Adjustment Department
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

If you are an electronic submitter, you may also fax your review request to 570-735-9599. Please refer to Chapter 1 of the *Region A DMERC Supplier Manual* for mailing addresses and telephone numbers for DME Regional Carriers.

- Our Customer Service Representatives also receive many calls regarding CO-16 denials. In most cases, an "M" message accompanies the CO-16 denial that tells you specifically what is missing. The most common remark codes are M51, M77, M78, MA82, MA83, and MA102. Please refer to Supplier Alert 98-09 for more specific information on "M" messages.

- Our MSP and Accounting Teams can now be contacted directly. You may contact the MSP Team directly at 570-740-9001 if you have any of the following denials: PR19, PR20, PR21, PR22, PR23, PR38, and CO-23. If your issues are concerning overpayments, offsets, copies of cancelled checks, returned equipment, claims billed with an incorrect HIC number or NSC number, or reissues of checks, you may contact the Accounting Unit at 570-740-9002.

Visit our website at www.medicare-link.com for Supplier Alerts Supplier Notices DMERC Medicare News



Region A Attends Retail Pharmacy Conference

United HealthCare, Region A DMERC, in conjunction with the other regional DMERCs, recently participated in the 1999 Pharmacy Conference & Managed Care Forum of the National Association of Chain Drug Stores (NACDS), which was held August 29 – September 1, 1999 at the San Diego Convention Center, San Diego, California.

The NACDS Pharmacy Conference is a forum where retail pharmacies ranging in size from 4 to over 4,000 locations learn the latest trends in health care and discuss issues concerning the industry. This is the first year all four regional DMERCs shared a booth at the Conference and presented a DMERC Update to the suppliers who were in attendance.

Representing Region A were Vikki Menichillo, Manager, Professional Relations and Brian Kapsick, Nutrition/Pharmacy Ombudsman.

Don't Miss Out - Get Your Supplier Notices and Alerts Via E-mail

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 e-mail as they are issued.

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

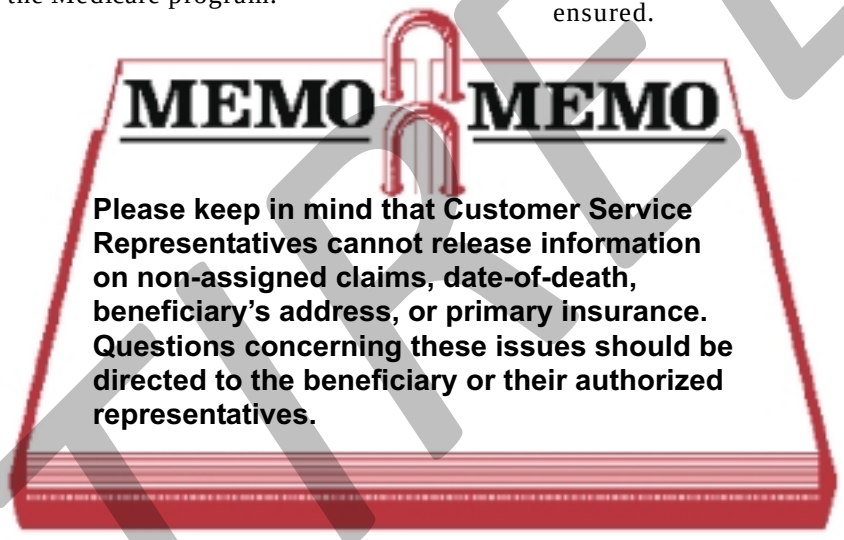
The e-mail must *not* contain a subject or any other text in the message. You will receive a confirmation by the listserve if you sent the e-mail properly.

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

Professional Relations Conducting Administrative Law Judge Seminars

In an ongoing effort to provide the highest quality of service, the Region A DMERC is conducting a series of training sessions for Administrative Law Judges (ALJs). United HealthCare Government Operations Division sponsored an Administrative Law Judge Conference on July 27, 1999. In addition to the Region A DMERC, there were also representatives from United HealthCare Medicare Part B, Empire Medicare, and the Health Care Financing Administration. A variety of topics were discussed covering all aspects of the Medicare program.

A second session was held August 13th, 1999 in Elkins Park, PA and concentrated specifically on surgical dressings and wound care. A third session is being held on September 28th and 29th in Camp Hill, PA. Sponsored by Highmark, presentations will also be given by intermediaries, carriers, and United HealthCare DMERC A for the Region III ALJs. A complete overview of the Medicare system is planned. By educating all levels of the system, from providers to ALJs, a strong degree of consistency throughout the process can be ensured.



Medical Policy

Medical Policy Revisions

DMERC regional medical review policy (RMRP) revisions have been published for the following policies:

- Commodes
- Oral Anti-Cancer Drugs
- Oral Anti-Emetic Drugs

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

- Commodes: the patient's weight will have to be entered on claims for extra wide/heavy duty commodes (K0457).
- Oral Anti-Cancer and Oral Anti-Emetic Drugs: the details of these two Medicare benefits had been previously published in various bulletins and are now being published in RMRP format.

RAD Policy Update

Supplier Notice 99-24, August 19, 1999

In the DMERC Regional Medical Review Policy on Respiratory Assist Devices (RAD) recently published in the *Region A DMERC Supplier Manual*, in the Coverage and Payment Rules section, there are several references to oximetry oxygen saturation values, "< (less than) 88%." At each of these references the symbol should be, "≤ (less than or equal to) 88%."

- Criteria for Group I (Restrictive Thoracic Disorders) have been changed, adding criterion (B)(3) as described below:

  I. Restrictive Thoracic Disorders

  A. There is documentation in the patient's medical record of a progressive neuromuscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB), and

  B. 1. An arterial blood gas PaCO2, done while awake and breathing the patient's usual FIO2, is ≥ 45 mm Hg, or

  2. Sleep oximetry demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing the patient's usual FIO2, or

  3. For progressive neuromuscular disease (only), maximal inspiratory pressure is < 60 cm H2O or forced vital capacity is < 50% predicted, and

  C. Chronic obstructive pulmonary disease does not contribute significantly to the patient's pulmonary limitation.

  Either Criterion B1 or B2 or B3 would qualify a patient with progressive neuromuscular disease, while criterion B1 or B2 would qualify a patient with severe thoracic cage abnormality for initial coverage of a K0532 or K0533.

- Accessories (K0183-K0268) are separately billable and reimbursable when used with a respiratory assist device without backup rate (K0532); they are NOT separately billable nor reimbursable when used with a respiratory assist device with backup rate (K0533 or K0534), since the latter has been placed in the frequent and substantially serviced (FSS) DME payment category. All accessories are already included in the monthly rental reimbursement for FS items.

- The effective date for the Respiratory Assist Devices regional medical review policy remains for dates of service on or after October 1, 1999.

Payment for Respiratory Assist Devices

Supplier Notice 99-22, August 19, 1999

On June 25, 1999, the Health Care Financing Administration (HCFA) held a public meeting regarding the appropriate durable medical equipment payment category for respiratory assist devices with bi-level pressure capability and with a backup rate feature. The meeting provided an opportunity for interested parties to furnish information and raise issues about the payment classification for these devices. At this time, HCFA is continuing to review the information presented at this meeting and has not yet reached a decision regarding this important issue. Therefore, until further notice regarding HCFA's decision on this issue, respiratory assist devices with bi-level pressure capability and with a backup rate feature (K0533 and K0534) will be included in the category for items requiring frequent and substantial servicing.

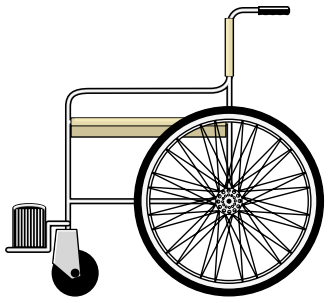
Timeliness of CMNs

Certificates of Medical Necessity represent an evaluation by the treating physician of a beneficiary's condition for which an item of medical equipment is being ordered. It may even serve as a substitute for a physician's order. For this reason, if too much time passes from the time a CMN is completed by the physician and the item is delivered to the beneficiary, the item may no longer be medically necessary or appropriate because of changes in the beneficiary's medical condition. Therefore, if greater than 3 months passes from the time a CMN is completed and signed by the physician and the item being ordered is delivered, a new CMN will have to be completed and signed for submission of a claim to the DMERC for reimbursement.

Note: The timeliness for initial oxygen CMNs is more restrictive. As has been previously published (*DMERC Medicare News*, March 1998), the date of oxygen testing must be within 30 days prior to the initial certification. Therefore, for initial oxygen certifications, the CMN may be completed by the physician no more than 30 days prior to initial coverage of oxygen.

Wheelchair Coding Reminder

Since January 1, 1994, all wheelchair claims, as well as CMNs, must be submitted using the proper "K" code. Any new wheelchair claims received with an "E" code will be denied. Suppliers may continue to submit "E" codes for any maintenance and servicing of wheelchairs provided prior to January 1, 1994.



Immunosuppressive Drug Coverage for Pancreas Transplants

Effective July 1, 1999, Medicare will cover pancreas transplantation when it is performed in a licensed facility at the same time or after a kidney transplant (HCPCS code 50360 or 50365). If the pancreas transplant occurs after the kidney transplant, the 36-month period of entitlement to the immunosuppressive therapy begins with the date of discharge from the admission for the pancreas transplant.

Billing Instructions for Pancreas Transplants

The following HCPCS codes for pancreas transplants should appear in Block 24d of the HCFA-1500: 48554 – Transplantation of pancreatic allograft.

This change will be incorporated into the immunosuppressive drugs medical policy in a future supplier manual revision.

HCPCS

HCPCS Codes K0193 and K0194 No Longer Valid as of October 1, 1999

Supplier Notice 99-25, August 19, 1999

HCPCS code K0193 (continuous positive airway pressure [CPAP] device, with humidifier) is no longer valid for submission to the DMERC for dates of service on or after October 1, 1999. To bill for this combination device, use HCPCS codes E0601 plus K0268 (humidifier, non-heated, used with positive airway pressure device).

If a K0193 was in service prior to the effective date of the policy, the first claim for code E0601 submitted for dates of service on or after October 1, 1999 must be billed as the next month that would have been reached in the capped rental period for the

K0193, using the appropriate KI, KJ, or MS modifier. Bill for the K0268 separately.

HCPCS code K0194 (intermittent assist device with continuous positive airway pressure device [CPAP], with humidifier) is no longer valid for submission to the DMERC for dates of service on or after October 1, 1999. To bill for this combination device, use HCPCS codes K0532 (see new Respiratory Assist Devices policy) plus K0268 (humidifier, non-heated, used with positive airway pressure device).

If a K0194 was in service prior to the effective date of the policy, the first claim for code K0532 submitted for dates of service on or after October 1, 199 must be billed as the next month that would have been reached in the capped rental period for the K0194, using the appropriate KI, KJ, or MS modifier. Bill for the K0268 separately.

New Product Classification Lists

Quarterly, the DMERC publishes updates to the following classification lists contained in the Appendices section of the *Region A DMERC Supplier Manual*:

- Enteral Nutrients
- Nebulizers
- Oral Anti-cancer Drugs
- Pneumatic Compression Devices (Lymphedema Pumps)
- Surgical Dressings
- Support Surfaces Group 1
- Support Surfaces Group 2
- Wheelchair Bases

These lists provide information on the appropriate HCPCS code to use when billing the DMERC for a particular product. In addition to the quarterly update to the lists noted above, two new lists have been developed and are contained as a supplement to this newsletter. The new lists are:

- Powered Operated Vehicles (POV)
- Walkers

If the product you are billing is not contained on a list or you are not sure of the appropriate code to use for billing an item to the DMERC, you may contact the SADMERC Helpline at 803-736-6809 for assistance. The SADMERC may also be reached by logging onto their website at

http://www.pgba.com/palmetto/main.nsf/allframesets/pro_sadm.html

or by writing to the address listed below:

SADMERC / HCPCS UNIT
P.O. Box 100143
Columbia, SC 29202-3143

E0610 and E0615 Cardiac Pacemaker Monitors

Cardiac pacemaker monitors are used to monitor patients with implanted pulse generators (pacemakers). There are 2 different types of devices that can be used to monitor a pacemaker:

- Transtelephonic pacemaker monitor
- Self-contained pacemaker monitor

Transtelephonic pacemaker monitors involve the use of the telephone to transmit a recording of the patient's heart rate / rhythm to a physician or some other entity such as a commercial monitoring service, hospital outpatient department, etc. The transmitting device that is furnished to and taken home by the patient is simply one component of the diagnostic system. The transmitter is not separately billable as durable medical equipment. The cost of the transmitter should be reflected in the charge for monitoring. Claims for transtelephonic monitoring are submitted to the Local Carrier.

Self-contained pacemaker monitors (E0610, E0615) allow the patient to monitor his / her pacemaker at home by an audible and / or visible signal or by a digital readout of the patient's pulse rate in beats per minute. These devices are used by the patient

in order to minimize the need for regular visits to the physician or to the outpatient department. The patient contacts their physician when there is a change in the pulse rate of 5 beats per minute above or below the initial rate of the pacemaker. It is not a device used for transtelephonic monitoring nor does it involve professional/physician services to read the monitor. Codes E0610, E0615 were established to describe self-contained pacemaker monitors.

Based on audit information and correspondence with manufacturers to determine if any products are currently manufactured that meet the definition of codes E0610 and E0615, it has been determined that there are no products manufactured at present that meet the definition of codes E0610 and E0615. Suppliers who feel that the particular self-contained cardiac pacemaker monitors for which they bill the DMERCs qualifies for code E0610 or E0615 are encouraged to contact these products' **manufacturers**. The manufacturer should then contact the SADMERC by **November 30, 1999** in order to initiate a review of their product. The SADMERC Help Line can be reached by calling 803-736-6809 from 9AM to 4 PM EST, or in writing at the following address:

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

They may also be reached by visiting their website:

http://www.pgba.com/palmetto/main.nsf/allframesets/pro_sadm.html

If suppliers have questions about the proper coding of equipment, it is suggested that they contact the SADMERC for coding determinations.

Billing of K0532

Supplier Notice 99-23, August 19, 1999

HCPCS code K0532 - Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) – has been placed in the Capped Rental DME payment category. Effective October 1, 1999, devices currently coded with HCPCS code E0452 must be billed using code K0532. Effective October 1, 1999, code E0452 will no longer be valid for billing to the DMERC.

If an E0452 was in service prior to the effective date of the policy, the first claim for code K0532 submitted for dates of service on or after October 1, 1999 must be billed as the next month that would have been reached in the capped rental period for the E0452, using the appropriate KI, KJ, or MS modifier.

Reviews

Adjustments vs. Reviews

When a claim is processed incorrectly due to an error on the part of the DMERC, a provider can request an adjustment. Some examples of these errors are incorrect date of death, incorrect number of units/services, or incorrect date of service.

Medical necessity denials may only be appealed through the review process. The most common medical necessity denial is denial code CO-50. In this or any case for review, indicate exactly what is to be reviewed and why you feel the claim was denied incorrectly. For further clarification on tips for claim adjudication, please refer to Supplier Notice 98-35, *Tips for Adjudicating Claims*, issued November 16, 1998.

The address to submit your adjustment request is:

United HealthCare
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attention: Adjustments

The address to submit your review request is:

United HealthCare
Region A DMERC
P.O. Box 6300
Wilkes-Barre, PA 18773-6300
Attention: Reviews

Suppliers who bill electronically may fax their review request using fax number (570) 735-9599. Please note that there is a limit of six pages on each fax transmission.

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 *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. 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. Please note that there is a limit of six pages on fax transmissions. Please see the "Electronic Reconsideration Express" Cover Sheet on page 18 of this newsletter.

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

Requesting a Fair Hearing or ALJ Hearing

How to Request a Fair Hearing

Those who have a right to a hearing are:

- a beneficiary
- a representative of the beneficiary's choice
- a supplier who has accepted assignment
- a supplier who is responsible for indemnification

Types of hearings

- On-the-Record Hearing – The decision is based on the facts on file and additional material evidence that is submitted. Oral testimony is not presented.
- Telephone Hearing – Oral testimony is presented, and the opportunity exits for oral challenge.
- In-person Hearing – The claimant or representative has the opportunity to appear in person and present oral testimony and written evidence supporting the claim, or challenge the information examined to deny the claim.

The following steps must be followed when requesting a fair hearing

- The request for a hearing MUST be in writing and signed by the party or his representative.
- The request must state the dissatisfaction with the carrier's review determination or with the timeliness in which the request for payment was acted upon, and a desire to appeal the matter further.

The time limit for filing a hearing request is six months from the date of the notice of the review or revised determination.

The Region A DMERC has developed a uniform method of submission to improve accuracy and better expedite your fair hearing request. The Hearing Request Form allows a hearings specialist to isolate and execute your claim needs. Please see the Hearing Request Form on page 19. It is important to communicate that this form is not mandatory, but may act as a guide to assist you when requesting a hearing.

Criteria for filing a fair hearing

- A review determination is a prerequisite for a hearing, except where the carrier takes an unreasonable time to act on the initial claim.
- The amount in controversy is $100 or more.
- Claims may be combined to meet the $100 requirement if:
  - The claims belong to the same beneficiary or the same assignee;
  - The claims submitted by an assignee can be for several beneficiaries;
  - The claims have been through the review process, except when an initial payment request has not been acted upon with reasonable promptness.
- The type of hearing requested must be clearly indicated on the request.

Helpful hints regarding fair hearings

- When checking on the status of a hearing, use the Hearing Case Number assigned by the DMERC on your hearing acknowledgment letter when contacting the Hearing Department.
- Do not submit duplicate requests for a hearing for the same claim.
- When requesting information regarding a hearing decision, send a written inquiry to the DMERC Fair Hearing Unit at:

  United HealthCare Ins. Co.
  Region A DMERC
  P.O. Box 6800
  Wilkes-Barre, PA 18773-6800
  Attn: Fair Hearing Unit

  Or, fax to: 570-735-9422

Do not send the request to the Fair Hearing Officers. Once they have rendered a decision on your case, they return the file to the DMERC.

- If you receive a hearing decision that is in your favor and additional payment is necessary, please wait 45 days before contacting the DMERC regarding this payment.

- All hearing requests are acknowledged within 10 days of receipt by the DMERC. If you have not received an acknowledgment letter within 20 days of submitting your request, please call the DMERC Fair Hearing Unit at 570-735-9513.

How to request an ALJ Hearing

Those who have a right to an Administrative Law Judge (ALJ) Hearing are:

- a beneficiary
- a representative of the beneficiary's choice
- a supplier who has accepted assignment
- a supplier who is responsible for indemnification

The following steps must be followed when requesting an ALJ hearing

- The request for an ALJ Hearing MUST BE IN WRITING AND SIGNED BY THE PARTY OR HIS/HER REPRESENTATIVE.
- The request must state the dissatisfaction with the hearing officer's fair hearing determination and a desire to appeal the matter further.

The time limit for filing an ALJ hearing request is 60 days from the date of the notice of the fair hearing determination.

The Region A DMERC has developed a uniform method of submission to improve accuracy and better expedite your ALJ hearing request. The ALJ hearing request form allows a hearings specialists to isolate and execute your claim needs. Please see the Administrative Law Judge Hearing Request Form on page 20. It is important to communicate that this form is not mandatory, but may act as a guide to assist you when requesting an ALJ hearing.

Criteria for filing an ALJ request

- A fair hearing determination is a prerequisite for an ALJ hearing.
- The amount in controversy is $500 or more.
- Fair Hearings may be combined to meet the $500 requirement.
  - The fair hearings must belong to the same beneficiary or the same assignee;
  - The fair hearings submitted by an assignee may be for several beneficiaries;
  - The 60 day filing time limit must be met for all involved; AND
  - The ALJ hearing request must identify them.

Helpful hints regarding ALJ hearings

- When checking on the status of an ALJ hearing, use the ALJ hearing case number (which is the same as the DCN) assigned by the DMERC on your ALJ acknowledgment letter when contacting the Fair Hearing Unit.
- Do not submit duplicate requests for the same ALJ hearing.
- When requesting information regarding an ALJ hearing decision, send a written inquiry to the DMERC Fair Hearing Unit at:
- United HealthCare Ins. Co.
  Region A DMERC
  P.O. Box 6800
  Wilkes-Barre, PA 18773-6800
  Attn: ALJ Hearings
  Or, fax to: 570-735-9422

Electronic Reconsideration Express
ERE
Cover Sheet

Please reconsider this claim for payment.
For reconsideration on a SINGLE PATIENT, fill out the following:
Specific Patient Information

Beneficiary Name: _____

Medicare Number (HIC #): _____

Control Number (s): _____

_____

For reconsideration on MULTIPLE PATIENTS:

Specific Patient Information is not required. Instead circle MULTIPLE above and circle on the attached EOMBs all the control numbers to be reviewed. The reason for reconsideration:

Sender's name: _____

Telephone number: _____

Number of pages faxed including cover sheet:

FAX with cover sheet to (570) 735-9402 or (570) 735-9599	or	MAIL with cover sheet to United HealthCare DMERC Region A 60 East Main Street Nanticoke, PA 18634-1685 Attn: Reconsideration Unit
limit of 6 pages (includes cover sheet)		unlimited number of pages

Reminder

1. Have this cover sheet attached on the front of the reconsideration and completely filled out.
2. Have EOMB(s) attached for each claim being reconsidered.

DMERC Region A Hearing Request Form

Our facility would, at this time, like to request a(n): Telephone Hearing ❑
On the Record ❑
In Person ❑

Fair Hearing for the Claimant(s) listed below:

Supplier Name: _____ NSC Number:_____

Phone Number: _____ Supplier Contact: _____

Beneficiary Name	Medicare Number	Control Number	Date of Service

Signature_____ Date ____/____/____

Mail to:
United HealthCare Ins. Co.
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: Fair Hearing Unit

Fax to:
570-735-9422

DMERC Region A
Administrative Law Judge Hearing Request Form

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

We are requesting an ALJ hearing for the claimant(s) listed below:.

Supplier Name: _____ NSC Number:_____

Phone Number: _____ Supplier Contact: _____

Beneficiary Name	Medicare Number	Control Number	Date of Service

Signature_____ Date ____/____/____

Mail to:
United HealthCare Ins. Co.
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: ALJ Hearings

Fax to:
570-735-9422

EDI

Auditing of Electronic Billers

As mandated by HCFA, an EDI audit will be performed on all electronic submitters six months after they begin submitting electronic claims. These audits verify the accuracy of information transmitted electronically as compared to the suppliers source documents. (Medical necessity is not being evaluated at this time.)

Six months after you begin billing electronically, you will receive notification that an audit will be conducted. A list consisting of beneficiary's names, dates of service and dollar amounts for the claims being audited will be included. This audit will be conducted by mail for your convenience.

You will be asked to submit a copy of the source documents for each claim being audited to our office within thirty days. The source documents being requested are a written order (e.g., prescription) signed and dated by the physician and / or the Certificate of Medical Necessity if required for the equipment being ordered.

Your will receive notification of audit results by mail. No new documentation will be accepted after the audit is completed.

If an acceptable accuracy rating is not achieved, a re-audit will be conducted for a new time period. Failure to achieve an acceptable rating on a re-audit will result in termination of your electronic billing privileges for three months. You will then be required to reapply for EDI privileges with the Region A DMERC.

EDI Support Team
Region A DMERC

VPIQ/Claim Status Inquiry

Claim status inquiry is a benefit for electronic billers, providing you, the submitter, the opportunity to verify claim status directly through the computer. You may check the status of claims, Monday through Friday during the hours of 6 A.M. to 9 P.M. EST. (this may vary due to maintenance needs). This system is a dial-up access system. You need to be assigned an ID, various passwords, and a low-cost dial number. To sign-up for this option, complete the Claim Status Inquiry Addendum located on our website at www.medicare-link.com.

Once signed up for VPIQ / Claim status inquiry, however, you must access the system every 30 days to keep it active, and the system requires a password reset every 90 days. If you fail to complete either of these functions your account will be deactivated, and you will need to reapply for this option.

For further questions, contact the EDI Help Desk at 570-735-9429.

Bulletin Board Times

The Bulletin Board System is available for transmission of claims 7 days a week with the following exceptions: (All times are Eastern Standard Time.)

- 12 midnight to approximately 6 A.M. (THIS TIME MAY VARY DUE TO MAINTENANCE NEEDS)
- 7 A.M. to approximately 8 A.M.
- 1 P.M. to approximately 2 P.M.
- 6 P.M. to approximately 6:30 P.M.

CMN Reject Report

The following is a list of the CMN Reject Errors, and the most common reasons for CMN Rejections. Please refer to this listing when verifying CMN Rejections. As with any claim, please *verify the HIC number* that was submitted. This will be located on the CMN Reject report, and this is the number that the CMN will be located under in our processing system.

Reject Code *Definition*

3030 Initial Date Dup – The EMC CMN was transmitted as an initial CMN. There is already an Initial CMN with the same initial date on file with the DMERC for this procedure code. This error usually occurs for the following reasons:

1. The supplier was trying to submit a revised or recert CMN and entered the wrong cert type. **(The supplier should correct the cert type and resubmit the claim.)**

2. The initial CMN being sent is a duplicate of CMNs previously sent. **(The claim will be processed based on the most current CMN on file with the DMERC.)** CMNs should only be transmitted with the claim if they are not already on file in our office, not with every claim.

The supplier should not resend a corrected initial CMN. The supplier will have to file a review on the claim that had the original CMN.

3031 Initial Date < Previous End Date – The CMN was transmitted as an Initial CMN and has an initial date that is prior to the end date of the CMN on file already for the same procedure code. This error usually occurs when a patient changes suppliers for rental equipment.

The claim will be processed based on the most current CMN on file with the DMERC.

Please verify that the CMN you are submitting is not a revised CMN that has an incorrect Cert Type of an initial.

The supplier should not resend a corrected initial CMN. The supplier will have to file a review on the claim that had the original CMN.

Reject Code *Definition*

3032 Current Recert/Revision Date < previous – This error usually occurs for the following reasons:

1. This certification is a duplicate of a previous revision/recertification sent in on a previous claim for the same procedure code. **(The claim will be processed based on the most current CMN on file with the DMERC.)**

2. The recertification date on the latest CMN is earlier than the revision/ recertificiation date on the previous claim. **(This usually occurs on Parenteral/Enteral claims.)** The claim will be processed based on the most current CMN on file with the DMERC. **For Parenteral/ Enteral claims this may cause your claim to be paid incorrectly.** If the claim is paid incorrectly, the supplier should submit for a review.

The supplier should not resend a corrected initial CMN. The supplier will have to file a review on the claim that had the original CMN.

3047 Recertification Initial Date invalid – The recert/revision CMN was transmitted with an initial date that is not the same as the initial date of the CMN currently on file for the same procedure code.

The claim will be processed based on the most current CMN on file with the DMERC.

Correct the initial date on the recert/revision CMN and resubmit the claim along with the CMN.

3048 Cannot recertify discontinued CMNs – The recert CMN which was transmitted cannot be accepted for this procedure code. The CMN on file with the DMERC for this procedure code has been discontinued.

3052 CMN CLSD–Non Rev – A revised CMN, which was transmitted, cannot be accepted for this procedure code. The CMN on file with the DMERC for this procedure code has been closed.

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 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— www.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.

Overpayments and Refunds

Refunds to Medicare

When sending a refund check:

- Please attach a copy of the remittance notice, especially if the refund was initially paid between 1993 and 1997.
- Indicate the specific reason for the refund. Examples: Billing error, duplicate payment, incorrect provider, services not rendered, and etc. Do not state "overpayment" only.

For duplicate payments, provide copies of both remittances. If there are two different providers, indicate which one was incorrectly paid.

Duplicate payments are defined as having the same Medicare number, date of service, beneficiary, provider, and / or same procedure code.

Please send refunds for overpayments to:

United HealthCare Ins. Co.
Region A DMERC
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: Accounting Department

Tracking and Reporting Procedures for Unsolicited/ Voluntary Refund Checks from Providers/Suppliers

All Medicare contractors receive voluntary refunds (i.e., monies received not related to an open accounts receivable). Carriers generally receive checks. Substantial funds are returned to the trust funds each year through such voluntary refunds.

OIG Initiatives—The Office of the Inspector General (OIG), working with the Department of Justice and the Health Care Financing Administration (HCFA), has two initiatives to help combat health care fraud and abuse, and to encourage health care providers to comply with the rules and regulations of Federal health care programs. These initiatives are: Compliance Program Guidances and Corporate Integrity Agreements (CIAs). The Compliance Program Guidances are voluntary while the CIAs are mandatory. Both initiatives are designed to ensure that the providers / suppliers refund inappropriately received Medicare monies back to the trust funds. Due to these new initiatives, it is anticipated that Medicare contractors will experience an increase in the number of voluntary refunds. Compliance Program Guidances are tailored to provide guidance, recommendations, and suggestions to health care providers / suppliers to assist in developing effective internal controls that promote adherence to applicable Federal and State law and the program requirements of Federal, State, and private health programs. These Guidances describe the fundamental elements of a compliance program. Among the suggestions and recommendations is that the health care provider / supplier should establish an internal self-monitoring process which will aid them in detecting potentially fraudulent and / or abusive practices which result in overpayments due to the Medicare program. Currently, Compliance Program Guidances have been published for the following entities: hospitals; home health agencies; clinical laboratories; and third-party medical billing companies. OIG will be issuing compliance program guidance for additional entities in the future. CIAs are entered into between a health care provider / supplier and OIG as part of a global settlement of a fraud investigation. Under the CIA (which can be for a period ranging from 3 to 5 years), the provider / supplier is required to undertake specific compliance obligations, such as designating a compliance officer, undergo training, and auditing. The provider / supplier must report regarding their compliance activities on an annual basis to OIG, which is responsible for monitoring the agreements.

Providers are to complete the Overpayment Refund form when returning voluntary refund checks so the monies would be credited timely and accurately. Providers, subject to a CIA, should report that information to us when sending in a voluntary refund for proper credit and reporting to OIG.

Carriers have been instructed to deposit any voluntary provider / supplier refund check that is payable to the Medicare program. Upon deposit, we are to apply monies against any established account(s) receivable.

Overpayment Refund Form

To Be Completed By Medicare Contractor

Contractor Deposit Control #	Date:
Contractor Contact Name:	Date of Deposit:
Contractor Address:	Phone #
	Contractor Fax:

To Be Completed By Provider/Physician/Supplier

Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.

Provider / Physician / Supplier Name:	Address:	
Provider / Physician / Supplier #		
Contact Person:	Phone #	
Check Number #	Amount of Check $	Check Date

Refund Information

For each claim, provide the following:

Patient Name:	HIC #
Medicare Claim Number	Claim Amount Refunded $
Reason Code for Claim Adjustment:	(Select reason code from list below. Use one reason per claim)

(Please list all claim numbers involved. Attach separate sheet, if necessary)

Note: If Specific Patient / HIC / Claim # / Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment:

For Institutional Facilities Only:
Cost Report Year(s) (If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? ☐ Yes ☐ No

Reason Codes:

Billing / Clerical
01 - Corrected Date of Service
02 - Duplicate
03 - Corrected CPT Code
04 - Not Our Patient(s)
05 - Modifier Added / Removed
06 - Billed in Error
07 - Corrected CPT

Error MSP / Other Payer Involvement
08 - MSP Group Health Plan Insurance
09 - MSP No Fault Insurance
10 - MSP Liability Insurance
11 - MSP, Workers Comp. (Including Black Lung)
12 - Veterans Administration

Miscellaneous
13 - Insufficient Documentation
14 - Patient Enrolled in an HMO
15 - Services Not Rendered
16 - Medical Necessity
17 - Other (Please Specify)

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.

Ombudsmen Assignments

Supplier Notice 99-13
May 28, 1999

The following is an update to the recent changes in Professional Relations and Ombudsmen assignments:

Name: *Suzanne Smetana*
Category: Mobility
Geographic Area: Upper New York State

Name: *Brian Kapsick*
Category: Nutrition Pharmacy
Geographic Area: Pennsylvania

Name: *Cheri Cross*
Category: Supports
Geographic Area: New York City and Long Island
(Cheri's assignment is effective June 1, 1999)

Name: *Thomas O'Connor*
Category: At Large
Geographic Area: At Large
(Thomas' assignment is effective June 1, 1999)

Thomas will be assigned to different categorical and geographic events on an "as needed" basis.

Region A DMERC Announces New Site Director

Supplier Notice 99-14
June 10, 1999

We are pleased to announce that Jeanne Mariani R.N., B.S.N., M.H.A., will become Director of the Region A DMERC effective June 21, 1999. Our current Director Fred Larsen will support Jeanne to ensure a smooth transition of leadership.

Jeanne has an extensive background in healthcare management; her previous experience includes Vice-president of Nursing, and also Chief Operating Officer, Mercy Hospital, Scranton, PA of the Mercy Health System, Cincinnati, OH.

Having joined the DMERC in 1997, as manager of Medical Review / Utilization Review, Jeanne has contributed significantly in focusing and enhancing the efforts of the DMERC Medical Review Team.

Jeanne looks forward to continuing and strengthening our relationship with suppliers and she is interested in developing new ways to provide quality service to the Medicare community.

Supplier Manual on Website

Supplier Notice 99-15
June 11, 1999

Sections of the Supplier Manual are now available on our website at: **http://www.medicare-link.com/dmerc**. The remainder of the manual will be added in the near future. The sections listed in red are not available. You will need the Adobe Acrobat Reader program to view these files. If you currently do not have the program, download instructions are listed on the website.

Clarification to Supplier Notice 99-15

Supplier Notice 99-16
June 14, 1999

This is a clarification to the previously printed Supplier Notice. It stated that the sections NOT available at this time were in red. They are actually in black print.

We apologize for any confusion this may have caused.

Year 2000 Testing via the Bulletin Board System

Supplier Notice 99-17
July 16, 1999

As of July 1, 1999, electronic claim vendors and providers may begin testing on our asynchronous Bulletin Board System (TBBS). The purpose of our Year 2000 (Y2K) testing is to confirm the successful transfer of claim data with future dates between your billing system and our Medicare claim collection facility. Although this testing does not certify your system for Y2K compliance, our Y2K test will show what will happen with claims created by your renovated billing system. You'll also find more information about Y2K on our website at www.medicare-link.com/y2k/contents.htm. We strongly encourage you to test your system after is has been renovated for Y2K.

To submit Y2K test claims, please follow the steps listed below.

1. Complete and fax or mail the attached questionnaire to the appropriate EDI department. After the EDI Department establishes your testing setup, you will be notified, either by phone or fax, of when you can send your initial test file and of the bulletin board phone number.

2. Our Y2K test system telephone number will be supplied at the time of setup. The test system will be available July 1, 1999 until January 20, 2000. Our test system will be set at the current date plus 364 days (e.g., July 7, 1999 will be processed as July 5, 2000).

3. When you access the system for the first time, use the word "new" for the initial logon password. As part of the logon process, reset your password. The test file you create should contain between 15 to 30 claims.

4. We suggest that you include the following dates in your test: 12/31/1999, 01/01/2000, leap-year 02/28/2000, 02/29/2000, and 03/01/2000.

5. Files submitted by 4:00 PM on any business day will be processed by noon the next business day. Please remember to download and review your Reject Report.

If you have any questions, please contact the DMERC EDI Department at telephone number (570) 735-9429.

Y2K Testing Questionnaire

Company Name_____

Current Submitter Number: _____

Address: _____

City_____ State: ____ Zip: _____

Contact Name:_____

Type of Format: NSF Version: ___ ANSI Version: ____

Mail or fax to:

DMERC Region A Fax: (570) 735-9510
United HealthCare Ins. Co.
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

Please be sure to include your phone and fax numbers.

Termination of Supplier Toll-Free Service Line

Supplier Notice 99-18
July 16, 1999

Effective September 1, 1999, the Toll-Free Service Line for Suppliers (877-482-9056) will no longer be available. After August 31, 1999, suppliers can reach the DMERC Customer Service Department by dialing (570) 735-9445.

Clarification to Wheelchair Accessories Table

Supplier Notice 99-19
August 3, 1999

Supplier Notice SN-99-19 was retracted. Refer to SN-99-20 for the corrected Wheelchair Accessories Table information.

Correction – Supplier Notice 99-19

Supplier Notice 99-20
August 4, 1999

Please disregard Supplier Notice 99-19, Clarification to Wheelchair Accessories Table. Please refer to the corrected version of the tables listed on the next page.

Wheelchair Accessories – Related Modifier Table

CAPPED RENTALS	MONTHS	MODIFIERS
K0195	1	RRKH
	2 – 3	RRKI
	4 – 10	RRKJ
	11 – 15	RRKJ (BP, BR, or BU)

INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT	MONTHS	MODIFIERS
K0020, K0022-K0028, K0100, K0114-K0116, E0192 E0962, E0965, K0029-K0033, K0054-K0058, K0065, K0079-K0080, K0088-K0089, K0098, K0102-K0105, K0107, K0452	RENTED UP TO PURCHASE PRICE (1 – 10)	RR
	PURCHASED NEW	NU
	PURCHASED USED	UE

EXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT	MONTHS	MODIFIERS
K0082-K0087	RENTED UP TO PURCHASE PRICE	RR
	PURCHASED NEW	NU
	PURCHASED USED	UE

INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT WITH A RIGHT OR LEFT OPTION	MONTHS	MODIFIERS
K0015-K0019, K0021, K0034-K0053, K0059-K0064, K0066-K0078, K0081, K0090-K0097, K0099, K0106	RENTED UP TO PURCHASE PRICE (1 – 10)	RRLT OR RRRT or RRLTRT(when 2 units are billed)
	PURCHASED NEW	NULT OR NURT or NULTRT(when 2 units are billed)
	PURCHASED USED	UELT OR UERT or UELTRT(when 2 units are billed)

CAPPED RENTALS WITH THE RIGHT OR LEFT OPTION	MONTHS	MODIFIERS
K0101	1	RRKHLT oR RRKHRT
	2 – 3	RRKILT or RRKIRT
	11 – 15	RRKJLT (BP, BR, OR BU) or RRKJRT (BP, BR or BU)

OTHER ACCESSORIES	MONTHS	MODIFIERS
K0108, L3964-L3966, L3968-L3970, L3972, L3974	RENTED UP TO PURCHASE PRICE	RR (RT and/or LT when appropriate)
	PURCHASED NEW	NU (RT and/or LT when appropriate)
	PURCHASED USED	UE (RT and/or LT when appropriate)

Date of Purchase

Supplier Notice 99-21
August 16, 1999

When submitting claims to the DMERC that require a date of purchase, you must include both the month and the year. The month and year will be considered a complete date. We will also accept the month, day and year of purchase as a complete date if all are supplied.

Examples:

12 / 97 – Complete Date

12 / 05 / 97 – Complete Date

1997 – Incomplete Date

Please note that you are still required to provide the brand name, make, and model number.

Reminder to EFT Providers

Supplier Notice 99-26
August 25, 1999

Please remember to fill out a new Electronic Fund Transfer (EFT) agreement whenever there has been changes to the banking information we have on file. Examples of changes include your bank is sold, your account numbers change, or you change banks.

If you do not notify us of the change(s), your EFTs may initially be directed to the new accounts. However, these funds will eventually start to be returned to Medicare. To eliminate this problem, please update your banking information with Medicare as soon as changes are made.

To receive a new EFT agreement, call 570-735-9429 or access one from our web site at www.medicare-link.com.

DMERC Medicare News

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

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