DMERC Medicare News

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HCFA's New Name

On June 14, 2001, U.S. Department of Health and Human Services (HHS) Secretary Tommy G. Thompson announced that the Health Care Financing Administration (HCFA) is changing its name to the Centers for Medicare & Medicaid Services (CMS).

According to Secretary Thompson, "To give the agency a new direction, a new spirit, it is necessary that we give it a new name — one that truly reflects the agency's vital mission to serve millions of Medicare and Medicaid beneficiaries across America."

DMERC A has begun making reference to CMS instead of HCFA in this publication, and you'll soon see CMS appearing in all of our communications. There will be a transition phase for both HCFA and its contractors while we exhaust existing stock of materials with the HCFA name, as well as update Web site content.

Visit the New PSC Web Site

TriCenturion, LLC, the DMERC A Program Safeguard Contractor (PSC), has launched their Web site. Suppliers can now access the site at **www.tricenturion.com** for:

- final medical policies
- draft medical policies
- fraud and abuse information

Visit the HealthNow DMERC A Web site, **www.umd.nycpic.com**, for the latest supplier manual revisions, newsletters, and supplier notices and alerts. Suppliers can also continue to access billing information and seminar information at our site.

Contractor Updating of the ICD-9-CM Codes

Beginning October 1, 2001, suppliers may begin using the updated International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) codes for claims submitted on or after October 1, 2001; the updated diagnostic codes must be used for services billed on or after January 1, 2002.

DMERC A is required to accept both old and new ICD-9-CM codes for claims received October 1, 2001 through December 31, 2001. This grace period gives suppliers sufficient time to obtain and integrate the latest version of the ICD-9-CM codes into their billing system. It is important for suppliers to use the most recent version of the ICD-9-CM coding book and to code to the highest level of specificity.

ICD-9-CM books can be obtained from:

- American Medical Association 800-621-8335
- Channel Publishing 800-248-2882
- Medicode 800-999-4600
- Any medical bookstore

Table of Contents

DMERC A Contacts

Supplier Caller Information Network	866-419-9458	Medicare Secondary Payer	570-740-9001
Beneficiary Caller Information Network	800-842-2052	National Supplier Clearinghouse	866-238-9652
Check Control/MSP Fax	570-735-9594	Program Education & Training	570-735-9666
EDI Fax	570-735-9510	Program Education & Training Fax	570-735-9442
EDI Helpdesk	570-735-9429	Program Inquiries Fax (Hearings & Reconsiderations)	570-735-9599
Hearings Voice Mail	570-735-9513	SADMERC	877-735-1326

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Billing

Power Wheelchair Billing Reminder

A recent audit completed by DMERC A has revealed that frequently medical records do not support the Certificates of Medical Necessity (CMNs) submitted for power wheelchairs. As stated in Chapter 14.18, Motorized/Power Wheelchair Base, in the DMERC A Supplier Manual, the patient who requires a power wheelchair is nonambulatory and has severe weakness of the upper extremities due to neurologic or muscular disease/condition. Equipment must be necessary and reasonable for the treatment of an illness or injury or to improve the function of a malformed body member.

A power wheelchair is covered when all of the following criteria are met:

1. The patient's condition is such that without the use of the wheelchair the patient would be bed or chair confined.
2. The patient's condition is such that a wheelchair is medically necessary and the patient is unable to operate a wheelchair manually.
3. The patient is capable of safely operating the controls for the power wheelchair.

A power wheelchair is covered if the patient's condition is such that the requirement for a power wheelchair is long term (at least 6 months.) Documentation requirements include a CMN which has been signed and dated by the treating physician and kept on file by the supplier.

The physician must be certain that the patient's medical record contains sufficient documentation of the patient's medical condition to substantiate the need for the items ordered. This information would generally include the patient's diagnosis, the nature and extent of the functional limitations of the patient, a copy of the completed CMN, and additional clinical information. The physician should also retain a copy of the order or have equivalent information in the medical record. The documentation of the patient's medical record would not routinely be sent to the supplier or to the DMERC A. However, the DMERC A may request this information in selected cases. Please reference Chapter 12.4, Documentation, in the DMERC A Supplier Manual.

POVs – Options and Accessories

The Medicare allowance for Power Operated Vehicles (POVs) includes all options and accessories that are provided at the time of initial issue, including but not limited to batteries, battery chargers, seating systems, etc. When these items are provided at the time of initial issue, they must not be billed separately. Medically necessary replacement accessories for beneficiary-owned POVs meeting Medicare coverage criteria are separately payable. Effective for claims with dates of service on or after January 1, 2002, a replacement item for a beneficiary-owned POV, including but not limited to replacement batteries, should be billed using the specific wheelchair option or accessory code if one exists. If a specific code does not exist, use code K0108 (Wheelchair component or accessory, not otherwise specified). Refer to Chapter 14.8, Wheelchair Options and Accessories, in the DMERC A Supplier Manual for a list of specific codes and for documentation requirements when billing K0108. Do not use code E1399 for miscellaneous replacement POV accessories.

Billing Practice Reminders

The DMERC A Benefit Integrity Clearinghouse has seen recurrent issues regarding the supplier billing practices below. The following article is to remind suppliers of proper billing practices when submitting claims to Medicare.

Assignment Violations

If a physician or supplier collects more than the applicable deductible and coinsurance for covered services on assigned claims, it will be considered an assignment violation even if the amount collected is shown on the claim or the excess is promptly refunded once the physician or supplier receives the Medicare payment. Suppliers violating the assignment agreement will be required by the Benefit Integrity Unit to refund the beneficiary in full for covered services.

Continued on page 4.

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Participating physicians/suppliers (those who have signed a Participation Agreement) must always accept assignment on all claims. It is considered an assignment violation if a supplier, physician or other health care provider who is participating fails to accept assignment. Only unmet deductible and applicable coinsurance amounts may be collected at the time of service. The law now provides that any person who knowingly, willfully, and repeatedly violates the assignment agreement shall be guilty of a misdemeanor subject to a maximum fine of $10,000 and/or six months imprisonment.

Non-participating suppliers may choose to accept or not to accept assignment. Non-participating suppliers may bill the beneficiaries in full up front only on non-assigned claims.

Advanced Beneficiary Notice (ABN)

An ABN must be used whenever a service is rendered that may be denied due to lack of medical necessity. Suppliers must inform the beneficiary in writing at the time of service that Medicare may not cover a service and why it may not be covered. The ABN must be specific as to the exact service being rendered (including procedure codes and description of each item) and the reason that Medicare will deny the charge(s). Please refer to Chapter 12 of the DMERC A Supplier Manual for an example of a valid ABN (waiver of liability). An authorization to release benefits that includes a blanket statement that states that a beneficiary is liable for all charges that their insurance may not cover is not an acceptable Medicare ABN.

Vision

Below are reminders to all vision suppliers:

- The itemized charges on claims submitted to Medicare should accurately match the exact charge for the glasses being supplied – whether the charges are covered or not. This will ensure that the beneficiaries receive Medicare Summary Notices (MSNs) that accurately lists all charges that they are liable to pay.
- As of April 21, 1999, HCPCS codes V2740-V2744, V2750, V2755, and V2780 deny with a "medical necessity denial" action code. The beneficiary is not responsible for payment for this service for claims in which the ZX modifier has been omitted. The ZX modifier may only be used when the requirement is met along with documentation to support the medical necessity.

Is your National Supplier Clearinghouse (NSC) Number currently active?

Suppliers should periodically contact the NSC to verify that their NSC number is still active. Your NSC number can be deactivated by the NSC for several reasons. NSC numbers can be deactivated if the supplier is not regularly submitting claims to the DMERCs. The numbers can also be deactivated if the supplier does not return the re-enrollment package to the NSC. Suppliers whose NSC numbers have been deactivated or who have decided to cancel their NSC number are no longer eligible to bill Medicare.

When providing services it is important to ask if the services are for a Medicare beneficiary. 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 NSC number. Therefore, any expenses for items supplied to a Medicare beneficiary on or after the effective date of the deactivation or revocation of the NSC number are the responsibility of the supplier. The beneficiary can only be held responsible for the expenses if the supplier has proof that the beneficiary was notified 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. The DMERC A suggests that suppliers have this statement in writing, signed and dated by the beneficiary, on the day of purchase. Failure to do so may result in having to refund the beneficiary in full for all services that would have been covered by Medicare. Suppliers are 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. Suppliers that fail to refund as required are subject to Civil Money Penalties under 1834(j) (4) of the Social Security Act.

If you have any further concerns regarding your supplier number, contact the NSC at 866-238-9652.

HIPAA for Electronic Billers - the Mystery Revealed

Under the Health Insurance Portability and Accountability Act (HIPAA), each supplier that has elected to submit claims electronically (to Medicare and other insurers) must submit all of their claims in compliance with the requirements found in the X12N 837 version 4010 implementation guide. If a supplier contracts with a clearinghouse to translate their claim data into the X12N 837 v.4010 format, then they must furnish the clearinghouse with all data required by the X12N 837 v.4010 format.

What on Earth Does this Mean?

The American National Standards Institute (ANSI) X12N is the underlying structure that all software used to communicate medical insurance information **MUST** be based upon by **October 16, 2002**. It is the structural foundation upon which your medical billing software must be based. The 837 simply refers to the claims part of your billing software. The X12N 837 v.4010 also identifies and standardizes all of the data that must be incorporated into the software by software vendors. The foundation upon which the ANSI X12N is based will allow for more electronic options and services in the future. The current standard that most Medicare billing software is based upon today is the National Standard Format (NSF).

In order for you to ensure that you will have software that meets the compliance requirements of the X12N 837 v.4010 by October 16, 2002, we strongly recommend that you communicate with your current software vendor, billing service, or clearinghouse about their plans to meet these HIPAA requirements. As an electronic biller, you cannot tell by looking at your office management or claims billing software in what format it is written. This is something you must ask your vendor or clearinghouse. If you utilize a billing service, the billing service would have to contact its software vendor.

By the way, some software vendors do have software today that is based on the ANSI X12N. However, version 4010 is *not* used in production anywhere by anyone! All insurance companies and software vendors are in the development and/or internal testing phase. More than likely, your software is based on the National Standard Format (NSF). If it is based on ANSI X12N today, it is not a HIPAA compliant version.

Therefore, EVERYONE will either have to receive upgraded software or new software from their software vendor. If you use a clearinghouse, the clearinghouse will have to upgrade its software to meet HIPAA requirements. You will be responsible for sending your clearinghouse all claims data required for the X12N 837 v.4010 format. Your clearinghouse will be able to assist you in this. You will be liable for all costs related to the translation services of a HIPAA compliant clearinghouse.

EDI Submitters Need to Know – HIPAA EDI Testing Requirements

The DMERC A, under the direction of the Centers for Medicare & Medicaid Services (CMS), is in the process of internal testing for HIPAA-related system changes. DMERC A will begin to conduct open testing of the HIPAA compliant claim transaction – the inbound ANSI X12N 837 version 4010 – in October 2001. This testing requirement applies to the software you use to bill Medicare and other medical insurance companies. If you or your vendor do not test your software for HIPAA compliance with DMERC A, you will no longer be able to bill your claims electronically and you will have to revert to paper billing.

CMS has adopted the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Testing Sub-workgroup's recommendations on the levels of testing that need to occur. A sample of some of the current certification and testing services available today are provided in the WEDI SNIP Testing and Certification White Paper found at **www.wedi.org**. There is also an appendix of organizations offering transaction certification products.

Continued on page 6.

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Software testing with a third party certification system is not mandatory. If a vendor, billing service, or clearinghouse tests their claims software with a certification system and receives a certificate of compliance, a test for compatibility and suitability for the Medicare claims process is all that will be necessary.

All required levels of testing are also available through DMERC A and this testing is free of charge. If an EDI submitter is using a vendor, billing service, or clearinghouse that has passed DMERC A testing requirements, then all of the clients of the vendor/billing service/clearinghouse will not be required to test with Medicare prior to acceptance of production claims unless they specifically request further testing. EDI submitters, in cooperation with their vendors, must request a testing appointment to ensure that they complete testing and correct any detected system/software problems prior to October 2002. Appointment slots will be assigned on a first come basis. We will not be able to guarantee testing by the end of September 2002 for entities that delay scheduling testing until late in the transition period. After October 16, 2002, you will not be able to use your current claims billing software to send claims or receive remittances from Medicare.

As of October 1, 2001 all new EDI submitters who do not use a DMERC A accepted billing service, clearinghouse, or software package and who want to begin sending electronic claims to Medicare must use software compliant with version 4010 of the inbound X12N 837 health care claim transaction set. As of October 1, 2001 all new EDI submitters who do use a DMERC A accepted billing service, clearinghouse or software package and who want to begin sending electronic claims to Medicare can use the currently supported transaction sets of that service, clearinghouse, or software vendor, but will need to transition when their support service adopts version 4010 of the inbound ANSI X12N 837 transactions on or before October 16, 2002.

By January 2002, we will begin to provide production parallel remittance files for remittance receivers or their vendors who request remittance testing in the new HIPAA compliant software. DMERC A strongly encourages this testing since version 4010 electronic remittance advice (ERA) includes reversal/correction processing for all adjustment claims, as required in the 835 Implementation Guide. With this new method, the original claim is resent on the electronic remittance as a void transaction and the adjustment is sent as a new claim. This process is known as Full Claim Adjustment (FCA). Current remittance receivers will automatically be sent production X12N 4010 835 remittance advice transactions on October 16, 2002.

When you are ready to schedule a test, call the DMERC

Elimination of CMS Free Billing Software

Since the late 1980s, the Centers for Medicare & Medicaid Services (CMS) has required DMERC A to offer free electronic billing software to our suppliers upon request. These generally simple pieces of software allowed our suppliers to submit electronic claims to Medicare, using Medicare specific electronic data interchange formats, either the National Standard Format (NSF), the UB-92, or the X12N 837 format. DMERC A was required to offer this software in order to increase electronic claim submissions. The software gave our suppliers an opportunity to try electronic billing at low cost, with the expectation that suppliers would experience the benefits and procure or develop more sophisticated practice management or billing software that would do additional functions. Additionally, use of this software reduced processing costs to the Medicare program as suppliers switch from paper to electronic claims.

With the advent of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards, there will no longer be Medicare specific electronic formats. The same format will be used by suppliers to submit claims to any payer. This is expected to reduce the costs of electronic transaction software for suppliers, and should encourage more suppliers to use electronic transactions. These changes have prompted CMS to assess whether or not to continue offering the free billing software in the post-HIPAA environment. CMS will require DMERC A to begin phasing out the free billing software requirement effective fiscal year 2004, approximately one year after HIPAA standards are implemented. This will give our suppliers enough time to find substitute software that can work with all payers. You will be notified when the transition period will begin to phase out the free billing software.

Medical Policy

Biofeedback for Urinary Incontinence

In a recent National Coverage Determination published in the Medicare Coverage Issues Manual, Section 35-27.1, coverage criteria are defined for biofeedback therapy for the treatment of urinary incontinence. The policy specifies that coverage can be considered when the therapy is rendered by a practitioner in an office or other facility setting. The policy specifically states that home use of biofeedback therapy for urinary incontinence is **not** covered. Biofeedback devices for home use for the treatment of urinary incontinence will be denied as not medically necessary.

If these devices are provided for home use, they must be billed to the DMERC A using code E1399 (Durable medical equipment, miscellaneous). The claim should include the manufacturer and brand name/number of the device and information describing the condition for which it is being used. This information should be entered in the HA0 record (narrative field) of an electronic claim or attached to a paper claim.

Physicians and suppliers should refer to information published by their local carriers and intermediaries for details concerning coding and coverage of biofeedback therapy in the office or other facility setting.

Medicare does cover home use of non-implantable pelvic floor electrical stimulators (PFES) for the treatment of urinary incontinence. See the article in the March 2001 *DMERC Medicare News* for additional information about PFES devices.

Hospital Beds Policy Revised

A revision, with consolidation of DMERC policies for all types of hospital beds and their accessories, is included in the accompanying DMERC A *Supplier Manual Revision.* The revisions involve coding guidelines and the new codes for heavy duty and extra heavy duty beds. The June 2001 *DMERC Medicare News* included a summary of the hospital bed codes and a history of their previous or current valid dates for billing to DMERC A. Please note that the Hospital Beds and Accessories regional medical review policy (Chapter 14.13) included in the accompanying revision replaces Chapters 14.13 - 14.17 in the DMERC A Supplier Manual.

Pressure Reducing Support Surfaces- Group 1 Policy Revised

In the accompanying DMERC A *Supplier Manual Revision* is Chapter 14.22, Pressure Reducing Support Surfaces - Group 1. This policy revision incorporates a recent coverage determination by the Centers for Medicare & Medicaid Services (CMS) that reclassified synthetic sheepskin pads and lambswool sheepskin pads (HCPCS codes E0188 and E0189, respectively) as durable medical equipment and placed them in the inexpensive or routinely purchased payment category. Effective for dates of service on or after January 1, 2001, codes E0188 and E0189 will be given coverage consideration by the DMERC.

As published in the June 2001 *DMERC Medicare News* article, the CMS instructions included a directive to the DMERC not to process previously denied claims unless requested by the supplier. Therefore, suppliers with claims for codes E0188 and E0189 with dates of service on or after January 1, 2001 that have previously been denied should request adjustments for those claims. Claims submitted for adjustment must comply with the requirements outlined in the Pressure Reducing Support Surfaces - Group 1 policy. **Do not simply resubmit the claim**. Claims resubmitted will be denied as duplicates.

Ostomy Policy Revised

Chapter 16.10, Ostomy Supplies, is included in the accompanying DMERC A *Supplier Manual Revision*. Revisions include updates to HCPCS codes since the policy's last publication, definition changes to help with clarity, and inclusion of material from various previously published newsletters.

Speech Generating Devices Policy Correction

Chapter 14.32, Speech Generating Devices (SGDs), published in the March 2001 DMERC A *Supplier Manual Revision* contains a typographical error in the Coding Guidelines section. The coding of mounting systems should read "Mounting systems necessary to place the SGD devices, switches and other access devices within reach of the patient must be coded *K0546*" and not K0547 as published. Please make a note of this change. The DMERCs will incorporate this correction in the next revision of the SGD policy.

Immunosuppressive Drugs Policy - DMERC Information Form (DIF) Completion

Effective for dates of service on or after October 1, 2001, a new DIF will no longer be required when a new drug is added to or replaces an existing drug in a beneficiary's immunosuppressive drug regimen or if an immunosuppressive drug's HCPCS code changes. This applies to beneficiaries who are currently receiving medications covered under the Medicare immunosuppressive drug benefit. Chapter 19.01, Immunosuppressive Drugs, of the DMERC A Supplier Manual will be revised at a later date to reflect this change.

For additional details on the Coverage and Payment rules, Coding Guidelines, and Documentation requirements, refer to Chapter 19.01.

Voice Amplifiers Covered by Medicare

The Centers for Medicare & Medicaid Services (CMS) has determined that voice amplifiers used by beneficiaries with impaired function of their larynx (which is still present) are eligible for coverage by Medicare. This decision is retroactive, and therefore applies to any dates of service on which these items were/are provided.

When billing for these items use HCPCS code L8499 (Unlisted procedure for miscellaneous prosthetic services), and include the name, model number, and manufacturer of the device.

A voice amplifier is not the same as a voice prosthesis, therefore, do not use the HCPCS codes that describe an artificial larynx (L8500), or tracheostomy speaking valve (L8501).

Oximetry Testing

Measurement of oxygen saturation in the capillary blood using an oximeter is an option for documenting medical necessity of home oxygen and respiratory assist devices. Suppliers are reminded that in order to be considered acceptable documentation, this test must be performed by a Medicare-approved provider.

A Medicare-approved provider may be a physician, hospital, nursing facility, home health agency, laboratory, or independent diagnostic testing facility (IDTF) that is enrolled with a local carrier, local intermediary, or regional home health intermediary (RHHI). Entities that just perform the technical component of a test (e.g., providing the oximeter for home sleep studies) which is then purchased and billed by the physician to the local carrier must also be an enrolled Medicare provider – even though they will not bill Medicare directly.

In addition, in order to be considered acceptable documentation, the test may not be performed by a DMEPOS supplier or anyone financially associated with or related to the supplier.

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Miscellaneous

COB Contractor Fact Sheet for Suppliers - Revised

The Centers for Medicare & Medicaid Services (CMS) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. CMS awarded the Coordination of Benefits (COB) contract to consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The awarding of the COB contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations are initiated from, and researched at the COB contractor. This is no longer the function of your local Medicare intermediary or carrier. Implementing this single-source development approach will greatly reduce the amount of duplicate MSP investigations. This will also offer a centralized, one-stop customer service approach, for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds. The COB Contractor provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, and suppliers.

Information Gathering

Medicare generally uses the term Medicare Secondary Payer or "MSP" when the Medicare program is not responsible for paying a claim first. The COB contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary's health care expenses first before Medicare. The table below describes a few of these methods and programs.

Method/Program	Description
Initial Enrollment Questionnaire (IEQ)	Beneficiaries are sent a questionnaire about other insurance coverage approximately three (3) months before they are entitled to Medicare.
IRS/SSA/CMS Data Match	Under the Omnibus Budget Reconciliation Act of 1989, employers are required to complete a questionnaire that requests Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.
MSP Claims Investigation	This activity involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.
Voluntary MSP Data Match Agreements	Voluntary Agreements allow for the electronic data exchange of GHP eligibility and Medicare information between CMS and employers or various insurers.

Provider Requests and Questions Regarding Claims Payment

Intermediaries and carriers will continue to process claims submitted for primary or secondary payment. Claims processing will not be a function of the COB contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local intermediary or carrier. In addition, continue to return inappropriate Medicare payments to the local Medicare contractor. Checks should not be sent to the COB Contractor. Questions

Continued on page 10.

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regarding Medicare claim or service denials and adjustments should continue to be directed to your local intermediary and carrier. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the COB Contractor. This investigation will be performed with the provider or supplier that submitted the claim. MSP investigations will no longer be a function of your local intermediary or carrier. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in CMS's Database

The COB Contractor is the sole authority to ensure the accuracy and integrity of the MSP information contained in CMS's database (i.e., Common Working File). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as necessary, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary, spouse and/or family member changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the COB Contractor. CMS also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage, and to report this information when filing claims with the Medicare program.

Termination and Deletion of MSP Auxiliary Records in CMS's Database

Intermediaries and carriers will continue to terminate records on the CWF where the provider has received information that MSP no longer applies (e.g. succession of employment, exhaustion of benefits). Termination requests should continue to be directed to your local intermediary or carrier. MSP records on the CWF that you identify as invalid should be reported to the COB Contractor for investigation and deletion.

Contacting the COB Contractor

Effective January 1, 2001, refer all MSP inquiries, including, the reporting of potential MSP situations, invalid MSP auxiliary files, and general MSP questions/ concerns to the COB contractor. Continue to call your local intermediary and/or carrier regarding claims-related and recovery questions. The COB Contractor's Customer Call Center toll free number is 800-999-1118 or TDD/TYY 800-318-8782. Customer service representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, Eastern Standard Time, except holidays. Clip and post this section in a handy place for access by your office and billing staff.

Expanded Coverage of Diabetes Self-Management Training

Diabetes Outpatient Self-Management Training is now a covered Medicare service for a wider variety of Medicare providers/suppliers. To qualify for payment under this benefit, the supplier of durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) must first be enrolled in the Medicare program and currently eligible to receive reimbursement for Medicare covered services. All suppliers must meet the American Diabetes Association's (the successor to the National Diabetes Advisory Board) National Standards for Diabetes Self-Management Education Programs that was published in *Diabetes Care*, Volume 23, Number 5. **If you are a DMEPOS supplier that wants to receive Medicare reimbursement for diabetes education, and meet the above qualification, you should contact the local Medicare carrier who services your area.** See **www.hcfa.gov/Medicare/incardir.htm** to determine the local carrier for your area. The carrier will require you to submit a completed Form HCFA-855, along with your ADA recognition certificate. After it has been determined that you meet the quality standards, you will be sent your billing number. Once you have received your Provider Identification Number (PIN), you can begin receiving reimbursement for this service.

Medicare Secondary Payer Based on Disability

Medicare is the secondary payer for people under age 65 who have Medicare because of disability (i.e. they have received 24 months of Social Security benefits) and who are covered under a large group health plan (LGHP) because of their employment or the current employment of a family member.

Criteria

A LGHP is sponsored or contributed to by an employer or employee organization (such as a union). The plan:

- provides health care to employees, former employees, the employer, business associates of the employer or their families, and
- cover employees of at least one employer with 100 or more full and/or part-time employees. Employers must follow the Internal Revenue Service aggregation rules to determine whether the 100 or more employee threshold is met.

The LGHP includes plans in which the employees pay all the costs.

A group health plan that covers employees of at least one employer that had 100 or more employees on 50% or more of its business days during the preceding calendar year meets the definition of a LGHP.

Special Notes

A LGHP that is a multiple or multi-employer plan may NOT exempt people enrolled through an employer with less than 100 employees from the Medicare Secondary Payer (MSP) disabled provision.

Medicare is the secondary payer for all disabled people enrolled in a LGHP where coverage is based on the current employment of the disabled person or the current employment of a member of his or her family.

Voluntary Refunds

When voluntarily refunding money to DMERC A, please be sure to use the amount listed in the NET field on the individual claim information on your provider remittance, not the amount listed in the provider paid field. The net amount reflects any interest paid by Medicare on the claim. Failure to refund the net amount will result in an overpayment letter showing a balance for the interest.

Offset Requests

Suppliers who are voluntarily requesting that we establish an overpayment on their claim(s) and would like to have the overpayment offset, must use the words "**Immediate Offset**" in their request. Offset requests received without the words "Immediate Offset" will NOT be put into offset.

Supplier Notices

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

Accounting Department Inquiries

Supplier Notice 2001-13
June 12, 2001

Effective immediately calls received by the DMERC A Caller Information Network (CIN, formerly Supplier Services) regarding questions of a financial nature will be handled by a specialized team of CIN representatives trained in financial concerns. Calls will no longer be transferred to the Check Control Unit (formerly the Accounting Department).

In the near future, all CIN representatives will be able to assist callers with financial concerns and the 570-740-9002 line will no longer be available for inquiries. This will eliminate the long-distance charges that callers now incur when calling the Check Control Unit directly.

This process change will provide additional trained staff to answer callers' financial questions leading to increased efficiency and reduced response time.

Duplicate Checks

Supplier Notice 2001-14
June 21, 2001

On June 1, 2001 a small volume of duplicate checks were issued with the same check number and dollar amount. This matter has been researched and the situation creating this error has been resolved.

If you received duplicate checks and have already cashed both checks, please do not send us a refund as one check will be returned to you by the bank as unpaid.

If you received duplicate checks and have not already cashed both checks, please cash one, void the other, and return the voided check to:
HealthNow NY, Inc. DMERC A
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: Check Control Department

In addition, as a result of this issue, remittance notices for June 4, 2001 were not mailed until June 11, 2001. We apologize for any inconvenience this may have caused.

Third Quarter Update: Drug Fees

Supplier Notice 2001-15
June 29, 2001

The fees listed below are effective July 1, 2001.

DRUG FEES

HCPCS CODE	DESCRIPTION	DOSAGE	FEE
J0285	AMPHOTERICIN B	50 MG	$11.06
J0286	AMPHOTERICIN B, ANY LIPID FORMULATION	50 MG	$88.66
J0895	DEFEROXAMINE MESYLATE	500 MG/5 CC	$13.50
J1170	HYDROMORPHONE	4 MG	$1.50
J1250	DOBUTAMINE HYDROCHLORIDE	250 MG	$2.97
J1325	EPOPROSTENAL	0.5 MG	$11.57
J1455	FOSCARNET SODIUM	1000 MG	$11.99
J1570	GANCICLOVIR SODIUM	500 MG	$33.89
J1820	INSULIN, INJECTION	UP TO 100 UNITS	$2.29
J2175	MEPERIDINE HYDROCHLORIDE	100 MG	$0.60
J2260	MILRINONE LACTATE	5 ML	$44.13
J2270	MORPHINE SULFATE	10 MG	$0.62
J2271	MORPHINE SULFATE	100 MG	$13.85
J2275	MORPHINE SULFATE, PF, STERILE SOL	10 MG	$2.00
J2545	PENTAMIDINE FOR AEROSOL INHALER	300 MG	$93.81
J2920	METHYLPREDNISOLONE SODIUM SUCCINATE	40 MG	$1.92
J2930	METHYLPREDNISOLONE SODIUM SUCCINATE	125 MG	$3.10

Continued on page 13.

HCPCS CODE	DESCRIPTION	DOSAGE	FEE
J3010	FENTANYL CITRATE	2 ML	$1.96
J3370	VANCOMYCIN HCL	500 MG	$5.20
J7500	AZATHIOPRINE, ORAL, TAB	50 MG	$1.25
J7501	AZATHIOPRINE, PARENTERAL	100 MG	$107.91
J7502	CYCLOSPORINE, ORAL	100 MG	$5.23
J7506	PREDNISONE,ORAL	5 MG	$0.02
J7507	TACROLIMUS, ORAL	1 MG	$2.91
J7508	TACROLIMUS, ORAL	5 MG	$14.55
J7509	METHYLPREDNISOLONE, ORAL	4 MG	$0.51
J7510	PREDNISOLONE, ORAL	5 MG	$0.03
J7513	DACLIZUMAB, PARENTERAL	25 MG	$397.29
J7515	CYCLOSPORINE, ORAL	25 MG	$1.31
J7517	MYCOPHENOLATE MOFETIL, ORAL	250 MG	$2.40
J7520	SIROLIMUS, ORAL	1 MG	$6.51
J9000	DOXORUBICIN HCL	10 MG	$50.96
J9001	DOXARUBICIN HCL ALL LIPID FORMS.	10 MG	$358.96
J9040	BLEOMYCIN SULFATE	15 UNITS	$289.37
J9065	CLADRIBINE	1 MG	$56.09
J9100	CYTARABINE	100 MG	$5.94
J9110	CYTARABINE	500 MG	$23.75
J9190	FLUOROURACIL	500 MG	$1.98
J9200	FLOXURIDINE	500 MG	$129.56
J9208	IFOSFAMIDE	1 GM	$156.65
J9265	PACLITAXEL	30 MG	$164.08
J9280	MITOMYCIN	5 MG	$127.40
J9290	MITOMYCIN	20 MG	$421.99
J9360	VINBLASTINE SULFATE	1 MG	$4.10
J9370	VINCRISTINE SULFATE	1 MG	$33.98
J9375	VINCRISTINE SULFATE	2 MG	$67.96
J9380	VINCRISTINE SULFATE	5 MG	$154.57
J9390	VINORELBINE TARTRATE	10 MG	$90.73
K0548	LISPRO		$2.27

NEBULIZER DRUG FEES

HCPCS CODE	MOD	DESCRIPTION	FEE
J7051		STERILE SALINE OR WATER	$0.21
J7608	KO	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	$5.06
J7608	KP	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	$5.06
J7608	KQ	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	$4.53
J7618		ALBUTEROL, CONCENTRATED FORM	$0.14
J7619	KO	ALBUTEROL, UNIT DOSE FORM	$0.47
J7619	KP	ALBUTEROL, UNIT DOSE FORM	$0.47
J7619	KQ	ALBUTEROL, UNIT DOSE FORM	$0.14
J7628		BITOLTEROL MESYLATE, CONCENTRATED FORM	$0.25
J7629	KO	BITOLTEROL MESYLATE, UNIT DOSE FORM	$0.33
J7629	KP	BITOLTEROL MESYLATE, UNIT DOSE FORM	$0.33
J7629	KQ	BITOLTEROL MESYLATE, UNIT DOSE FORM	$0.25

Continued on page 14.

HCPCS CODE	MOD	DESCRIPTION	FEE
J7631	KO	CROMOLYN SODIUM, UNIT DOSE FORM	$0.24
J7631	KP	CROMOLYN SODIUM, UNIT DOSE FORM	$0.24
J7631	KQ	CROMOLYN SODIUM, UNIT DOSE FORM	$0.14
J7635		ATROPINE, CONCENTRATED FORM	$0.16
J7636	KO	ATROPINE, UNIT DOSE FORM	$0.37
J7636	KP	ATROPINE, UNIT DOSE FORM	$0.37
J7636	KQ	ATROPINE, UNIT DOSE FORM	$0.16
J7637		DEXAMETHASONE, CONCENTRATED FORM	$0.10
J7638	KO	DEXAMETHASONE, UNIT DOSE FORM	$0.21
J7638	KP	DEXAMETHASONE, UNIT DOSE FORM	$0.21
J7638	KQ	DEXAMETHASONE, UNIT DOSE FORM	$0.10
J7639	KO	DORNASE ALPHA, UNIT DOSE FORM	$15.87
J7639	KP	DORNASE ALPHA, UNIT DOSE FORM	$15.87
J7639	KQ	DORNASE ALPHA, UNIT DOSE FORM	$15.79
J7642		GLYCOPYRROLATE, CONCENTRATED FORM	$0.31
J7643	KO	GLYCOPYRROLATE, UNIT DOSE FORM	$0.83
J7643	KP	GLYCOPYRROLATE, UNIT DOSE FORM	$0.83
J7643	KQ	GLYCOPYRROLATE, UNIT DOSE FORM	$0.31
J7644	KO	IPRATROPIUM BROMIDE, UNIT DOSE FORM	$3.34
J7644	KP	IPRATROPIUM BROMIDE, UNIT DOSE FORM	$3.34
J7644	KQ	IPRATROPIUM BROMIDE, UNIT DOSE FORM	$2.92
J7648		ISOETHARINE HCL, CONCENTRATED FORM	$0.17
J7649	KO	ISOETHARINE HCL, UNIT DOSE FORM	$0.21
J7649	KP	ISOETHARINE HCL, UNIT DOSE FORM	$0.21
J7649	KQ	ISOETHARINE HCL, UNIT DOSE FORM	$0.17
J7658		ISOPROTERENOL HCL, CONCENTRATED FORM	*IC
J7659	KO	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.40
J7659	KP	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.40
J7659	KQ	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.31
J7668		METAPROTERENOL SULFATE, CONCENTRATED FORM	$0.25
J7669	KO	METAPROTERENOL SULFATE, UNIT DOSE FORM	$1.42
J7669	KP	METAPROTERENOL SULFATE, UNIT DOSE FORM	$1.42
J7669	KQ	METAPROTERENOL SULFATE, UNIT DOSE FORM	$0.25
J7680		TERBUTALINE SULFATE, CONCENTRATED FORM	$2.13
J7681	KO	TERBUTALINE SULFATE, UNIT DOSE FORM	$2.34
J7681	KP	TERBUTALINE SULFATE, UNIT DOSE FORM	$2.34
J7681	KQ	TERBUTALINE SULFATE, UNIT DOSE FORM	$2.13
J7682	KO	TOBRAMYCINE, UNIT DOSE FORM, 300 MG	$44.69
J7682	KP	TOBRAMYCINE, UNIT DOSE FORM, 300 MG	$44.69
J7682	KQ	TOBRAMYCINE, UNIT DOSE FORM, 300 MG	*IC
J7683		TRIAMCINOLONE, CONCENTRATED FORM	$0.04
J7684	KO	TRIAMCINOLONE, UNIT DOSE FORM	$0.15
J7684	KP	TRIAMCINOLONE, UNIT DOSE FORM	$0.15
J7684	KQ	TRIAMCINOLONE, UNIT DOSE FORM	$0.04
Q0163		DIPHENHYDRAMINE HYDROCHLORIDE, 50 MG	$0.02
Q0164		PROCHLORPERAZINE MALEATE, 5 MG	$0.57
Q0165		PROCHLORPERAZIEN MALEATE, 10 MG	$0.86

Continued on page 15.

This bulletin should be shared with all health care practitioners and managerial members of the supplier staff. All bulletins are available at no-cost from our Web site at www.umd.nycpic.com.

HCPCS CODE	MOD	DESCRIPTION	FEE
Q0166		GRANISETRON HYDROCHLORIDE, 1 MG	$44.69
Q0167		DRONABINOL, 2.5 MG, ORAL	$3.28
Q0168		DRONABINOL, 5 MG, ORAL	$7.66
Q0169		PROMETHAZINE HYDROCHLORIDE, 12.5 MG, ORAL	$0.07
Q0170		PROMETHAZINE HYDROCHLORIDE, 25 MG, ORAL	$0.02
Q0171		CHLORPROMAZINE HYDROCHLORIDE, 10 MG, ORAL	$0.07
Q0172		CHLORPROMAZINE HYDROCHLORIDE, 25 MG, ORAL	$0.09
Q0173		TRIMETHOBENZAMIDE HYDROCHLORIDE, 250 MG, ORAL	$0.43
Q0174		THIETHYLPERAZINE MALEATE, 10 MG, ORAL	$0.56
Q0175		PERPHENAZINE, 4 MG, ORAL	$0.57
Q0176		PERPHENAZIEN, 8 MG, ORAL	$0.93
Q0177		HYDROXYZINE PAMOATE, 25 MG, ORAL	$0.26
Q0178		HYDROXYZINE PAMOATE, 50 MG, ORAL	$0.27
Q0179		ONDANSETRON HYDROCHLORIDE, 8 MG, ORAL	$25.15
Q0180		DOLASETRON MESYLATE, 100 MG, ORAL	$69.64
Q9920		EPOETIN	$10.00

*INDIVIDUAL CONSIDERATION

July 2001 Fee Schedule Update

Supplier Notice 2001- 16
July 6, 2001

The July 2001 DMEPOS fee schedule update is available on the DMERC Web site at **www.umd.nycpic.com**. The July fee schedule update will not be published in the supplier manual revisions. If you do not have access to the Web site, you may request a copy from our Freedom of Information (FOI) Unit:

HealthNow DMERC A
Attention: FOI
60 East Main St.
Nanticoke, PA 18634
Fax: 570-735-9422

Please note that all requests must include the signature of the requestor.

Attention: All VPIQ Users

Supplier Notice 2001- 17
August 1, 2001

As of the close of business September 28, 2001, the HealthNow NY, Inc. DMERC A will no longer cover the costs associated with dial-up network access for VPIQ (VIPs Provider Inquiry System) Claim Status and Eligibility Inquiry functions. VPIQ dial-up network access costs will now be the responsibility of your company and will be charged to you directly should you choose to continue using VPIQ.

DMERC A has made arrangements with IVANS, a reseller of network access services, to continue offering your company dial-up access to the VPIQ system. Current VPIQ users will be receiving a mailing of contractual documents and current rates shortly. All documents must be fully executed directly with IVANS no later than **September 24, 2001** to ensure uninterrupted access to VPIQ by your company. Please be sure to include sufficient information on the returned documents, including your DME number, to clearly identify your company and location. This is particularly important if you are part of a multi-entity company.

Continued on page 16.

DMERC A will disconnect all current dial-up access connections for VPIQ as of close of business September 28, 2001.

Please contact Team EDI at 570-735-9429 with questions concerning these changes, or if you do not currently have VPIQ access and are interested in obtaining more information on this service.

See page 17 for the Ivans Communications Service Agreement.

Updated List - Non-Routine Medical Supplies

Supplier Notice 2001- 18
August 2, 2001

DMERC A published a listing of HCPCS codes that were subject to home health consolidated billing in the December 2000 edition of the *DMERC Medicare News*. Based upon revisions to the procedure codes, we are issuing a new list of HCPCS codes that, when billed during a home health episode, are subject to denial because payment is provided to the home health agency creating the episode. The new list of HCPCS codes is effective for claims with dates of service January 1, 2001 through December 31, 2001 that are submitted to the DMERC July 1, 2001 and later:

A4212	A4346	A4379	A4481	A5123	A6215	A6251
A4310	A4347	A4380	A4622	A5126	A6219	A6252
A4311	A4348	A4381	A4623	A5131	A6220	A6253
A4312	A4351	A4382	A4625	A6020	A6221	A6254
A4313	A4352	A4383	A4626	A6021	A6222	A6255
A4314	A4353	A4384	A4649	A6022	A6223	A6256
A4315	A4354	A4385	A5051	A6023	A6224	A6257
A4316	A4355	A4386	A5052	A6024	A6228	A6258
A4319	A4356	A4387	A5053	A6154	A6229	A6259
A4320	A4357	A4388	A5054	A6196	A6230	A6261
A4321	A4358	A4389	A5055	A6197	A6231	A6262
A4322	A4359	A4390	A5061	A6198	A6232	A6266
A4323	A4361	A4391	A5062	A6199	A6233	A6402
A4324	A4362	A4392	A5063	A6200	A6234	A6403
A4325	A4364	A4393	A5071	A6201	A6235	A6404
A4326	A4365	A4394	A5072	A6202	A6236	A6405
A4327	A4367	A4395	A5073	A6203	A6237	A6406
A4328	A4368	A4396	A5081	A6204	A6238	A7501
A4329	A4369	A4397	A5082	A6205	A6239	A7502
A4330	A4370	A4398	A5093	A6206	A6240	A7503
A4331	A4371	A4399	A5102	A6207	A6241	A7504
A4332	A4372	A4400	A5105	A6208	A6242	A7505
A4333	A4373	A4402	A5112	A6209	A6243	A7506
A4334	A4374	A4404	A5113	A6210	A6244	A7507
A4335	A4375	A4421	A5114	A6211	A6245	A7508
A4338	A4376	A4455	A5119	A6212	A6246	A7509
A4340	A4377	A4460	A5121	A6213	A6247	
A4344	A4378	A4462	A5122	A6214	A6248	

Billing Reminder - CPM

Supplier Notice 2001-19
August 6, 2001

The Continuous Passive Motion (CPM) device for the knee (E0935) is the only such device eligible for coverage and reimbursement through the DMERC. All of the following criteria must be met:

- The device must be prescribed by a physician.
- The patient must have undergone a total knee replacement.
- The use of the device must commence within two days of the date of surgery.

Coverage is limited to that part of a 21-day period, beginning with the date of surgery, during which the device is used in the patient's home.

Documentation of the following dates must accompany the claim. The dates for paper claims should be written on the claim or submitted on an attachment and for an electronic claim should be submitted in the HA0 record (narrative field).

- date of surgery
- date CPM therapy began
- date of discharge

Claims submitted without the above information will be denied for missing information.

IVANS, Inc. Communications Service Agreement

Customer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Customer Contact: _____ Title: _____

Phone: _____ Fax: _____

Billing Address: _____

(if different from above)

City: _____ State: _____ Zip: _____

Contact: _____ Phone: _____

(if different from above)

E-Mail Address: _____

User IDs:

_____

_____

_____

_____

_____

_____

_____

If additional User IDs, attach separate sheet.

HealthNow (Account TMED) ("Sponsor") has authorized you to use the IVANS Network for access to certain services provided that you agree to pay IVANS' charges which will consist of:

Monthly Service Charge	$ 7.00
Charge for Prime-Time use of SNA Dial, prorated	$ 5.50/hour
Charge for Non Prime-Time use of SNA Dial, prorated	$ 3.25/hour
Fee 800 Number, if used, prorated	$ 5.50/hour

You also agree that your access to the IVANS Network Facility will be subject to the terms and conditions printed on the reverse side of this agreement.

Customer:

By: _____ Name: _____

(Authorized Signature) (Type or Print)

Title: _____ Date: _____

(Type or Print)

Mail or fax both sides of this completed agreement to:

IVANS' Agency & Vendor Services, Account Manager
5405 Cypress Center Drive
Tampa, FL 33609-1022

Should you have any questions about this agreement or if you desire to contact IVANS for any reason please write: IVANS, Inc., 5405 Cypress Center Drive, Tampa, FL 33609-1022, or call the IVANS Helpdesk at 1-800-548-2675, Fax 813-282-7029.

10/21/94 x 7/23/01 Healthnow-TMED

This bulletin should be shared with all health care practitioners and managerial members of the supplier staff. All bulletins are available at no-cost from our Web site at www.umd.nycpic.com.

IVANS, INC. COMMUNICATIONS SERVICE AGREEMENT

Under this Agreement, you, the Customer ("User"), may access the *IVANS* network on the following terms and conditions:

1. ***IVANS'* SERVICE**: The service consists of access to the *IVANS* Network for the purpose of using communication, information, database or computing services authorized for you by an *IVANS'* Member or Subscriber Member ("Sponsor"). Use of these services is subject to this agreement and any supplemental operating terms and conditions including copyright and confidentiality notices published in connection with individual services, options or facilities. *IVANS'* may suspend your access to this service without notice at your Sponsor's direction or at *IVANS'* discretion in the event your Sponsor does not maintain it's membership status in *IVANS*.

2. **ACCESS TO NETWORK**: Access to the *IVANS* network will be provided on a schedule made available to User, but may be limited at the discretion of *IVANS* for emergency repairs or as a result of circumstances beyond *IVANS'* control.

3. **CHARGES**: Use of services or products other than those shown on the first page of this Agreement will lead to additional charges based on *IVANS*= current rates for those services and products. *IVANS* reserves the right to modify charges effective thirty (30) days after notice to User. *IVANS* also reserves the right to add or withdraw products and services with notice to user. All charges are exclusive of federal, state or local sales, use, or personal property taxes or taxes of a similar nature. Any such taxes which may be applicable will be paid by User or by *IVANS* for User's account. User acknowledges and agrees that it shall be solely responsible for any long distance telephone charges necessary for access to the *IVANS* network. Termination or suspension of account for non-payment, and subsequent re-activation, may incur an additional charge.

4. **BILLING AND PAYMENTS**: Customer will be invoiced on a schedule established by *IVANS*, with recurring charges billed in advance and with payment due within 21 days of the date of invoice. If User learns or suspects that unauthorized use of this account is taking place, it must notify *IVANS* immediately and, in such event, *IVANS* will cancel User's password and provide User with a new one. Delinquent accounts are subject to interest charges of one and one-half (12%) percent per month or the maximum limit allowable by law on the unpaid balance, whichever is less, plus all costs of collection, including reasonable attorney's fees. *IVANS* reserves the right to suspend service to a delinquent account without notice.

5. **LIMITATION OF WARRANTY**: CUSTOMER EXPRESSLY AGREES THAT USE OF THE SERVICE AND MATERIAL THEREIN AND STORAGE OF INFORMATION WHICH APPEARS IN THE SERVICE IS AT CUSTOMER'S SOLE RISK. NEITHER *IVANS* NOR ANY OF ITS LICENSORS, SUPPLIERS, OR AGENTS WARRANTS THAT THE SERVICE WILL BE UNINTERRUPTED OR ERROR FREE; NOR IS ANY WARRANTY MADE AS TO THE RESULTS TO BE OBTAINED FROM USE OF THE SERVICE. THE SERVICE IS DISTRIBUTED ON AN "AS IS" BASIS WITHOUT WARRANTIES OF ANY KIND, EITHER EXPRESS OR IMPLIED INCLUDING BUT NOT LIMITED TO WARRANTIES OF TITLE OR IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE.

6. ***IVANS* LIABILITY**: *IVANS* exclusive liability for any claim of any kind relating to this Agreement or to the products and services provided hereunder shall not exceed the fees paid for use of the services and *IVANS* liability shall terminate if no action is commenced within one year after a cause of action has occurred. IN NO EVENT SHALL *IVANS* BE LIABLE FOR SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL DAMAGES, INCLUDING WITHOUT LIMITATION DAMAGES TO GOODS OR EQUIPMENT, LOST PROFITS, DOWNTIME COSTS, LABOR COSTS, OVERHEAD COSTS, CLAIMS OF CUSTOMERS OR CLIENTS OR USER, OR DELIVERY OF DATA CONTAINING INACCURACIES OR OMISSIONS THAT WERE PRESENT WHEN THE DATA WAS RECEIVED BY *IVANS*.

   Some states do not allow the limitation or exclusion of liability for incidental or consequential damages, so the above limitation or exclusion may not apply to you.

7. **INDEMNIFICATIONS**: Customer shall indemnify and hold *IVANS* and its affiliates harmless from all claims made by Customer's employees, clients or customers or their employees, clients or customers.

8. **TERM**: This agreement will remain in effect until written notice of termination for any reason is rendered by either party to the other. If dedicated lines, frame relay or similar products are in use, the Customer must provide sixty (60) days advance written notice of termination. Notwithstanding anything to the contrary, IVANS has the right to terminate this agreement if Customer files for bankruptcy.

9. **ASSIGNMENT**: This Agreement may not be assigned by Customer without the prior written consent of *IVANS*.

10. **GOVERNING LAW**: This Agreement is to be governed by and interpreted in accordance with the laws of the State of Connecticut.

11. If customer is a corporation, partnership or other business entity, the individual agreeing to these terms has full authority and power to enter into this agreement. No terms or conditions in any purchase order or other document shall supersede the terms of this Agreement.

10/21/94 x 7/23/01 Healthnow TMED

Change of Address

If you have moved, please let the National Supplier Clearinghouse (NSC) know. The NSC needs your new address and telephone number to update your file and ensure that your Medicare paymentsand mailings will be sent to the correct address.

This change applies to (check one):

- ❑ Street Address
- ❑ Mailing Address
- ❑ "Pay to" Address
- ❑ All Three Address Types

**** IMPORTANT NOTES ****

A separate form is required for each type of address changed unless your street address, mailing address, and your "pay to" address are the same. If all addresses are the same, please choose "All Three Address Types" above.

An authorized representative on file with NSC must sign this form.

Name of Physician/Supplier: _____

Previous Address: _____

City, State, Zip Code:_____

New Address: _____

City, State, Zip Code:_____

Telephone Number:_____ Ext:_____

Tax ID Number: _____ Supplier Number:_____

Fax Number: _____ E-Mail Address: _____

I certify that I have examined the above information and it is true, accurate, and complete. I understand that any misrepresentation or concealment of material information may subject me to liability under civil and criminal laws.

Name of Authorized Representative:_____ Title:_____
(TYPED OR PRINTED)

Signature:_____ Date:_____

Return this completed form to:

Palmetto Government Benefits Administrators, LLC
National Supplier Clearinghouse
Post Office Box 100142
Columbia, South Carolina 29202-3142

DMERC Email Inquiries - New Address

The DMERC A has established a new email address for suppliers to send their inquiries; the new address is **dmerc.pr@healthnow.org**.

Please remember that email messages sent to DMERC A are considered written correspondence and DMERC A has up to 45 calendar days to respond to these inquiries.

When sending email messages, the supplier's name is required in addition to the name of the person submitting the inquiry. If we are unable to determine the source of the inquiry, we will send a return message requesting the identity of the inquirer. Our responses must follow the provisions of the Privacy Act. Please do not include Medicare numbers, Social Security numbers, personal medical information, or other confidential items in your e-mail inquiry. If you have a question about a specific claim, please contact our Supplier Service Unit by calling 866-419-9458 between the hours of 7:30 a.m. and 4:30 p.m.

Requests for information covered under the Freedom of Information Act (FOIA) must be submitted to our office in writing with the signature of the requestor. Requests sent via email will be returned to the sender with instructions for submitting the request in writing.

As of Tuesday, August 28, 2001, email inquiries sent to the mailto.dmerca@healthnow.org address will be returned to the sender with instructions to forward the message to the new address. Please remember to update you email address book.

DMERC Medicare News

HealthNow New York Inc. DMERC A ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800

Suppliers: This newsletter should be directed to your billing manager.