DMERC Medicare News

DMERC A Service Office ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800 ◆ Phone 866-419-9458 ◆ www.umd.nycpic.com
Number 62 ◆ June 2002

Discontinuation of Printing and Mailing of Bulletins for the Remainder of Fiscal Year 2002

Due to budgetary constraints, the Region A DMERC will **not** be printing and mailing the June and September 2002 issues of the *DMERC Medicare News*, nor the *Supplier Manual Revisions (Numbers 022 and 023)*. **However, the bulletins will be available on our Web site at www.umd.nycpic.com/dmprovpublcopy.html (supplier manual updates at www.umd.nycpic.com/dmrmrpcopy.html).** After accepting the CPT License Agreement, you can access the entire online collection of bulletins, which includes May 1993 to the present. Bulletins are posted on our Web site by the third week of the last month of the quarter, i.e., the June 2002 bulletin will be posted by June 21, 2002.
Providers/suppliers without Internet access can request hardcopy versions by calling the Supplier Toll-Free Number (**866-419-9458**) or by submitting a request in writing to: HealthNow New York Inc., Attention: Program Inquiries, P.O. Box 6800, Wilkes-Barre, PA 18773-6800.

Visit the DMERC A Web Site for Your Informational Needs

There have been recent changes to the Region A DMERC Web site; namely, an "Education" section has been added. This section features information the Centers for Medicare & Medicaid Services (CMS) issues for publication, links to *DMERC Medicare News* articles, and information that is important for you to know. To access the Education section of the DMERC A Web site:

- Visit **www.umd.nycpic.com**
- Click on "DMERC A"
- Under "Suppliers," click on "Education"
  [**www.umd.nycpic.com/dmeduc.html**]

Check it out TODAY!!

Please Note: Current CMS initiatives are mandating the DMERCs to post Medicare information to their Web sites. Therefore, suppliers and providers are encouraged to visit the DMERC A Web site for their informational needs.

Subscribe to the DMERC A ListServe

Want to get the latest information? The Region A DMERC ListServe is a feature on the DMERC A Web site. The ListServe is used to notify subscribers via email of important and time-sensitive Medicare program information, upcoming provider education and training events, and other important announcements or messages. Subscribers will also receive notice of the availability of the quarterly *DMERC Medicare News* on our Web site.
To receive reminders and announcements via email, you may join the ListServe by visiting: **www.umd.nycpic.com/dmlistserve.html**. Subscribe to the Region A DMERC ListServe by typing your email address in the box provided at the ListServe page.
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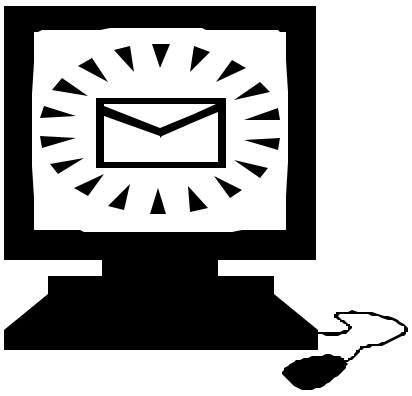

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DMERC A Contacts

Supplier Toll-Free Number	866-419-9458	National Supplier Clearinghouse	866-238-9652
Beneficiary Toll-Free Number	800-842-2052	Program Education & Training	570-735-9666
Beneficiary Toll-Free Number (PA only)	800-Medicare	Program Education & Training Fax	570-735-9442
Check Control/MSP Fax	570-735-9594	Program Inquiries Fax (Hearings & Reconsiderations)	570-735-9599
EDI Fax	570-735-9510	Program Inquiries Voice Mail (Hearings)	570-735-9513
EDI Helpdesk	570-735-9429	SADMERC	877-735-1326

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Billing

Clarification of Billing Requirements for Maintenance and Servicing for Capped Rental Items

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers must not submit claims for maintenance and servicing until all claims for rental have been paid and six (6) months have passed from the end of the final **paid** rental month. (See Medicare Carriers Manual, §5102.1.E.4.) Furthermore, DMEPOS suppliers must not bill for maintenance and servicing codes on the same claim as codes for the rental itself.

[Reference: Change Request (CR) 2136; Transmittal 1752]

Common Working File (CWF) Changes for Emergency Home Dialysis Supplies for Method II Beneficiaries

Medicare pays for dialysis equipment and supplies for qualified beneficiaries with end stage renal disease (ESRD) who choose to perform self-dialysis in the home. Method I ESRD beneficiaries choose to receive their home dialysis equipment and supplies from a Medicare certified dialysis facility, which bills the appropriate fiscal intermediary. Method II ESRD beneficiaries choose to receive all of their home dialysis supplies and equipment directly from a home dialysis supplier. Method II suppliers must accept assignment on all home dialysis claims, must be the sole supplier of home dialysis supplies and equipment for the beneficiary, and must bill the DMERC servicing the beneficiary's home state. The DMERCs pay for Method II dialysis based on a monthly capitation rate. Under normal circumstances, Method II suppliers may only receive payment up to the monthly cap. However, Medicare does allow an exception to this rule. Method II ESRD beneficiaries may keep one month's worth of home dialysis supplies on hand for emergency situations, and the DMERC may make payment for the emergency supplies over and above the normal monthly cap for home dialysis payments. The Method II suppliers identify the emergency supplies on their claims using modifier "EM", which stands for "emergency reserve supply (for ESRD benefit only)."

Prior to January 1, 2002, Method II suppliers billed for the emergency supplies using "kit codes", which bundled various home dialysis supplies into a single code. However, effective January 1, 2002, the Centers for Medicare & Medicaid Services (CMS) discontinued use of the "kit codes." Now that the "kit codes" are no longer available, suppliers must individually bill for every supply item that they used to include in the kits. **To facilitate this change in policy, CMS is requiring that Method II suppliers bill all emergency reserve items within the same month of a calendar year, with the "EM" modifier on each affected line item.** This requirement applies to the following Healthcare Common Procedure Coding System (HCPCS) codes:

A4651	A4652	A4656	A4657	A4660	A4663	A4670
A4680	A4690	A4706	A4707	A4708	A4709	A4712
A4714	A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4730	A4736	A4737	A4740	A4750
A4755	A4760	A4765	A4766	A4770	A4771	A4772
A4773	A4774	A4801	A4802	A4860	A4870	A4890
A4911	A4913	A4918	A4927	A4928	A4929	

Current CWF edits only allow for one line item to have the "EM" modifier. However, due to the elimination of the "kit codes," DMERCs now need the ability to process multiple line items with an "EM" modifier. Until CWF can correct this problem, the DMERCs have been forced to suspend claims that they would otherwise process. Medicare pays for one month's emergency reserve supply for Method II home dialysis patients, once in a patient's lifetime for each dialysis modality the patient receives. CWF and the DMERC standard and local systems (if applicable) must make any systems changes necessary to pay for these emergency reserve supplies correctly and in a timely fashion.

◆**Until these systems changes can be made, the DMERC is requesting Method II suppliers not to submit claims for dates of service on or after January 1, 2002**. You will be notified via our Web site (**www.umd.nycpic.com/dme_what's_new.html**), ListServe, and upcoming *DMERC Medicare News* when you may submit these claims.

[Reference: Change Request (CR) 2044; Transmittal B-02-014]

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Payment for Method II Home Dialysis Supplies When the Beneficiary is an Inpatient

Per Section 4271.2 of the Medicare Carriers Manual, Method II suppliers may bill Medicare only for the amount of supplies that a beneficiary actually used in the month before the supplier submits a monthly claim. Therefore, in the month following a home dialysis patient's inpatient stay, the supplier must reduce the monthly delivery of, and billing for, new supplies to account for the supplies the Method II patient did not use during his or her inpatient stay. This policy applies only to Method II patients who have had an inpatient stay lasting **at least 3 days**, not including the date of admission or the date of discharge.

If the inpatient stay begins at the end of one month, and carries over into the following month, suppliers should prorate their bills for the month following the second month of the inpatient stay.

Suppliers must prorate from the allowed charge (the monthly cap), rather than their submitted charges. Since the beneficiary does not return the equipment to the supplier during a period of hospitalization, the supplier may continue to bill in full for the rental of home dialysis equipment.

The Centers for Medicare & Medicaid Services (CMS) requires that all Method II suppliers have a written agreement with a support service renal facility, which maintains the beneficiary's medical records. Method II suppliers should encourage support service facilities to notify them when the facility becomes aware that a beneficiary became an inpatient for part of a month. When the support service facility notifies the supplier of a beneficiary's inpatient stay, the supplier must prorate its bill for the next month's supplies for that beneficiary. Similarly, suppliers should request that the beneficiaries they service inform the supplier when they are an inpatient.

As with any other Medicare claims, the supplier billing for home dialysis supplies and equipment must complete all required information on the claim form, including any codes or modifiers required by CMS or its contractors.

[Reference: Change Request (CR) 1799; Transmittal 1743]

Home Blood Glucose Monitors – Unbundling "Kits"

Effective for **dates of service on or after January 1, 2002**, the paragraph and table in the Coding Guidelines section of the Home Blood Glucose Monitors local medical review policy (LMRP), dealing with bundling of accessories and supplies (Column I and Column II), is being deleted.

In the December 2001 *DMERC Medicare News*, an article was published regarding home blood glucose monitors and the "starter kit" supplies that are often bundled with new monitors. Several suppliers and manufacturers have contacted the Durable Medical Equipment Regional Carriers (DMERCs) to obtain clarification of the instructions contained in that article. Specifically, suppliers want guidance on how to bill for supplies that are not included with the starter kits at the time of initial monitor issue.

Answer: A supplier may bill for test strips and other supplies that they themselves package together with the monitor and ship to the beneficiary. However, items that are received by the supplier free of charge (such as those items included in "starter kits") may not be billed. In other words, suppliers must not charge a beneficiary for items that the supplier receives for free.

Suppliers are allowed to bill Medicare for additional supplies that may be necessary for the beneficiary to monitor their blood glucose at the time of initial issue of a home blood glucose monitor. For example, a beneficiary purchases a new blood glucose monitor. Included with the purchase of the monitor are a small number of test strips and lancing devices. However, there are only enough strips and lancets to perform about a week of testing so the beneficiary also purchases a box of 50 test strips, 100 lancets and two vials of control solution. In this example, the supplier may bill Medicare for the monitor, the box of 50 test strips, 100 lancets and the two vials of control solution. The supplier must not bill for the small number of test strips and lancing devices that were included with the new monitor.

Refer to the LMRP on Home Blood Glucose Monitors in the *DMERC Region A Supplier Manual* for additional information regarding Coverage and Payment Rules and Coding Guidelines for these items.

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Correction - Billing for Blood Glucose Test Strips and Supplies

A previously published article in the March 2002 edition of the *DMERC Medicare News* instructed suppliers to file claims for blood glucose supplies and test strips on behalf of the beneficiary for dates of services on or after October 1, 2001. The following information is an update to the previously published requirement.

Effective April 1, 2002, suppliers must file claims for blood glucose supplies and test strips on behalf of the beneficiary for dates of services on or after **April 1, 2002**. Medicare will no longer accept claims filed by the beneficiary. Suppliers must also complete the "from" and "to" dates in Block 24 of the HCFA-1500 (CMS-1500) form when filing claims for blood glucose supplies (codes A4253, A4255, A4256 and A4259). The "from" and "to" dates cannot be exact duplicates.

The Home Blood Glucose Monitors local medical review policy will be revised at a later date to incorporate this change.

[Reference: Change Request (CR) 1612; Transmittal B-01-74]

Billing Glucose Test Strips and Supplies - New Remark Code

For claims processed with dates of service on or after April 1, 2002, suppliers will receive the following new remark code when billing with the same "from" and "to" dates in Block 24 of the HCFA-1500 (CMS-1500) form:

N64 - The "from" and "to" dates must be different.

This remark will be applied at the service level on the Remittance Advice.

[Reference: Change Request (CR) 1612; Transmittal B-01-74]

Change to Medicare Checks

In accordance with the Health Care Financing Administration's (HCFA's) name change to the Centers for Medicare & Medicaid Services (CMS), the HCFA logo has been removed from the Medicare checks. Therefore, you may notice a change in the appearance of your checks.

[Reference: Change Request (CR) 1964; Transmittal AB-01-173]

Reminder - Ostomy Supplies

As referenced in the local medical review policy (LMRP) # 16.10 for Ostomy Supplies, under documentation requirements: "The supplier must enter the diagnosis code for the ostomy on **each claim** submitted for ostomy supplies. If more than one ostomy, enter the appropriate codes." Without this information, claims may be denied.

New NDC Numbers For Methotrexate

Suppliers are currently instructed to bill oral anti-cancer drugs to the DMERCs using the appropriate National Drug Code (NDC) number.

Four additional NDC numbers have been added for methotrexate products:

Methotrexate, 5mg, oral	(NDC #00555-0927-01)
Methotrexate, 7.5mg, oral	(NDC #00555-0928-01)
Methotrexate, 10mg, oral	(NDC #00555-0929-01)
Methotrexate, 15mg, oral	(NDC #00555-0945-01)

These numbers are valid for claims with dates of service on or after April 30, 2001 that are **received on or after July 1, 2002**.

[Reference: Change Request (CR) 2064; Transmittal B-02-016]

New Message for Advanced Beneficiary Notice (ABNs) Denials

Effective July 1, 2002, the Centers for Medicare & Medicaid Services (CMS) is issuing new Medicare Summary Notice (MSN) and Medicare Remittance Notice (MRN) messages for use when the Durable Medical Equipment Regional Carriers (DMERCs) deny a claim due to invalid ABN upgrade information. Therefore, the following messages will be used when denying claims:

MSN # - 8.53: "This item or service was denied because the upgrade information was invalid."

MRN# - N108: "This item/service was denied because the upgrade information was invalid."

These messages will be applied at the claim line level.

[Reference: Change Request (CR) 2084; Transmittal B-02-029]

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Billing Invalid/Incorrect Modifiers

A modifier allows the health care professional to indicate that the service or procedure performed was altered by a specific circumstance but not changed in its definition or code. The modifying circumstance is identified by adding a modifier to the basic procedure code.

Therefore, claims submitted to the Region A Durable Medical Equipment Regional Carrier (DMERC) with an invalid/incorrect modifier will be denied. **The modifier must also be valid for effective dates of service.** Please review the appropriate local medical review policies (LMRPs) for the correct modifiers and refer to previous bulletins for clarification of usage and effective dates.

If the claim is denied for invalid/incorrect modifier you will receive a unprocessable claim (return/reject) action code, which will allow you to resubmit as a new claim. In this case, please do not attach a Remittance Advice (RA) or Medicare Summary Notice (MSN) to the claim. You will need to correct or add the information needed and submit as you would a new claim.

Skilled Nursing Facility (SNF) Contracting with Outside Entities for Ancillary Services

Except for those services and supplies specifically excluded, under consolidated billing an outside provider or supplier can no longer submit a separate bill directly to Medicare for services furnished to a SNF resident during a covered stay. Instead, it must look to the SNF for its payment. [*Please see the related article on page 16 of this edition*]

Effective April 1, 2002, for claims processed and adjusted with dates of service on or after April 1, 2001, outside providers or suppliers will receive the following alert when billing for services or supplies that are subject to consolidated billing and should have been submitted to the SNF for payment:

> **N73 - A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents. Only the professional component of physician services can be paid separately.**

This remark will be applied at the service level on the remittance advice.

[Reference: Change Request (CR) 1764; Transmittal AB-01-159]

HCPCS

Use of KX Modifier with Code L0430

In the December 2000 *DMERC Medicare News*, an article was published announcing that the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) was developing a product classification list for HCPCS code L0430 (TLSO, anterior-posterior-lateral control (body jacket), with interface material, custom fitted). Manufacturers were instructed to contact the SADMERC for a coding determination if they believed their product(s) meet the definition of code L0430. To date, the following products have been reviewed by the SADMERC and coded L0430:

- Johnson's Orthopedic Design T.L.S.O.
- Camp Healthcare TLSO Jacket (Model 8262S and 8262F)

Effective for dates of service on or after October 1, 2002, suppliers billing code L0430 must include a KX modifier if the specific product being delivered to the beneficiary appears on the SADMERC product classification list. Only those products appearing on the SADMERC product classification list may be coded L0430. Claims for HCPCS code L0430 billed without a KX modifier will be denied for incorrect coding.

Suppliers wanting to know which products have been coded L0430 by the SADMERC should consult the SADMERC Web site at **www.palmettogba.com**, then go to "Other Partners" and click on "SADMERC," or call the SADMERC Helpline at **877-735-1326**. [**www.palmettogba.com/palmetto/Other.nsf/Home/Other+Medicare+Partners+SADMERC+Home?OpenDocument**]

2002 Jurisdiction and Noncovered Items Lists

The HCPCS codes that have been added or discontinued (deleted) for this year, and the noncovered items, are available through the DMERC A Web site at **www.umd.nycpic.com**, or through the Region A Program Safeguard Contractor (TriCenturion, LLC) Web site at **www.tricenturion.com**.

[Reference: Change Request (CR) 2051; Transmittal B-02-015]

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HIPAA Model Compliance Extension Plan and Instructions Now Available

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) became law. It requires, among other things, that the Department of Health and Human Services establish national standards for electronic health care transactions and code sets. October 16, 2002 is the deadline for covered entities such as health plans, clearinghouses and providers (such as physicians, dentists, hospitals, nursing homes and others) to comply with these new standards. However, in December 2001, the Administrative Simplification Compliance Act (ASCA, Public Law 107-105) gave covered entities not compliant by October 16, 2002 the opportunity to extend their compliance deadline by 1 year – to October 16, 2003. This extension opportunity is applicable to all HIPAA covered entities other than small health plans (those with less than $5 million in annual receipts whose compliance date is already set for October 16, 2003). In order to qualify for this extension, covered entities must submit a compliance plan by October 15, 2002.

A model compliance plan and instructions on how to complete and submit it are available on the Centers for Medicare & Medicaid Services (CMS) Web site, **www.cms.hhs.gov/hipaa**. You can submit this on-line model plan electronically through the Web site or print and mail it. You can submit your own paper version of the plan as long as it provides equivalent information (covered entity and contact information; reasons for filing for the extension; HIPAA implementation budget information; and where you are in implementing and testing, including whether or not you plan to use a vendor). The CMS strongly encourages electronic filing but if you must file on paper, you should send your form to Attention: Model Compliance Plans, Centers for Medicare & Medicaid Services (CMS), P.O. Box 8040, Baltimore, MD 21244-8040. The deadline for both electronic and paper submissions is October 15, 2002.

If you file electronically through the Web site, you will receive an electronic confirmation number acknowledging and granting your extension. If you file a paper version, you won't receive a confirmation, but if your paper plan consists of the required equivalent information, you may consider your extension granted. The instructions give more details on how to complete the form; explanation of who should file for an extension; data you need to include; and where to get more information on definitions, frequently asked questions, etc.

For more information, submit questions to **askhipaa@cms.hhs.gov**.

Providers Using Medicare Supplied Billing Software

Medicare contractors will continue to provide electronic billing software for providers to use to submit their Medicare claims. The HIPAA compliant version of this software may not be available until December 2002. As this is after the initial compliance deadline of October 16, 2002, any providers that plan to use the current version of this software after October 15, 2002 must submit a Compliance Extension Plan as described above.

[Reference: Change Request (CR) 2168; Transmittal AB-02-071]

Reminder - VPIQ Users

As of April 1, 2002, VPIQ (ViPs Provider Inquiry System) was changed as part of the Health Insurance Portability and Accountability Act (HIPAA) mandated 276/277 transaction sets (refer to PM AB-01-106, CR 1784). The "ALL" entry in the HICN field for options A, C, R and O is no longer a valid option. All VPIQ users should have received a new User Manual, to reflect the changes, by May 6, 2002. If you have **not** received your new manual, please call Team EDI at 570-735-9429.

Accelerate Software Update

Effective May 1, 2002, the Region A DMERC will no longer supply a communications package with our Accelerate software. With the increased cost of printing and copying, the price of the Accelerate billing software will remain at $25.00.

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.

Utilizing the X12N 837 (Version 4010) When Submitting Medicare Secondary Payer (MSP) Claims

Effective October 16, 2002, Part B physicians and suppliers must submit all electronic MSP claims data to Medicare using the ANSI X12N 837 (version 4010), unless physician and suppliers request a one year extension to comply with HIPAA version 4010 under the provisions of the Administrative Simplification Compliance Act. Currently, there are fields to identify the other payer's allowed and paid amount on the 837, however, there is no field on the 837 to specifically identify the Obligated to Accept as Payment in Full (OTAF) amount. The OTAF amount is a payment (which is less than your charges) that you are obligated to accept or agreed to accept as payment in full satisfaction of the patient's payment obligation. On most claims, the OTAF amount is greater than the amount the primary payer actually paid on the claim. The Medicare program uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.

When you migrate to the X12N 4010 837, you must use the line level contract information (CN1) segment to report the OTAF. Report the OTAF in CN102 (Contract Amount) with a qualifier of "09" (Other) in CN101. If MSP data is received at the claim level, report the OTAF in 2300 CN102. If MSP data is received at the line level, report the OTAF in 2400 CN102. The X12N 4010 837 Professional Implementation Guide allows for claim level OTAF reporting using the CN1 segment as described above, as well as line level reporting using the line level CN1 segment. Furnish line level primary payer data, including the OTAF amount, when available. The chart below identifies the segments and data elements that you must use to report: (1) the submitted charges, (2) the primary payer paid amount, (3) the primary payer allowed amount, and (4) the OTAF amount at the claim and the service line levels.

[Reference: Change Request (CR) 2007; Transmittal B-02-025]

	837/3051	NSF	837 v 4010	Comments
Claim Total Submitted Charge	2-130-CLM02	XA0-12	2300 CLM02	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Paid Amount	2-300-AMT02 AMT01 = D	DA1-14	2320 AMT02 AMT01 = D	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim Primary Payer Allowed Amount	2-300-AMT02 AMT01= B6	DA1-11	2320 AMT02 AMT01 = B6	Must be equal to the sum of the lines if the lines are available. If the lines don't equal, return the claim to the physician or supplier.
Claim OTAF Amount			2300 CN102 CN101=09, if 2400 CN101=09 is not available	Must be equal to the sum of the lines. If the lines don't equal, return the claim to the physician or supplier. The claim level CN1 should be used only when the service line CN1 is not available.
Line Submitted Charge	2-370-SV102	FA0-13	2400 SV102	None
Line Primary Payer Paid Amount	2-475-AMT AMT01 = D	FA0-35	2430 SVD02	None
Line Primary Payer Allowed Amount	2-475-AMT02 AMT01= B6	FB0-06	2400 AMT02 AMT01 = AAE	If there is no value in the Allowed Amount field, use the value in the Approved Amount field.
Line OTAF	2-475-AMT02 AMT01=CT	FA0-48	2400 CN102 CN101 = 09	None

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Standard Provider Remittance (SPR) Changes

The Health Insurance Portability and Accountability Act (HIPAA) mandated that the standard Medicare processing system create a new electronic remittance advice (ERA) flat file (also known as the 835 transaction). The Centers for Medicare & Medicaid Services (CMS) is requiring that the Standard Provider Remittance (SPR) match the ERA.

The following information will give you an overview of the changes to the SPR, which are effective July 1, 2002:

1. "Amount paid to beneficiary," and "MSP amount" fields used to compute provider payment will now be reported as reason code adjustments, rather than in separate fields.
2. There is a new claim level field for the informational reporting of late filing reductions.
3. There is also space to provide the submitted HCPCS/NDC code and the paid HCPCS/NDC code at each service line. If the submitted HCPCS/NDC code and the paid HCPCS/NDC are the same, only the paid HCPCS/NDC code will be printed on the SPR. For DMERC drug claims, the SPR will continue to print only the NDC code; the 'WW' procedure code will not be shown on the SPR.
4. The "Total Offset" field has been renamed as "Provider Adj."
5. The "total paid to beneficiary," and "total other adjustments" fields have been deleted at the provider level.
6. The patient account field is expanded to 20 bytes.
7. The glossary section will be renamed to **GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes. Mnemonics Crosswalk.** You will notice new mnemonics on the revised SPR. The mnemonics have been changed to match the 4010 mnemonics. We are providing the following crosswalk for your convenience:

Old	New	Definition	Old	New	Definition
BF	FB	Forward Balancing	RI	CS	Adjustment
AP	AP	Acceleration of Benefits	RF	B2	Rebate (refund)
OF	WO	Withholding	PA	B2	Rebate (payout)
IN	I6	Interest	LF	50	Late Filing (10% late filing reduction)

SPR Balancing

As with an 835, the amounts reported in a paper remittance advice must balance at the transaction, the claim and the service line levels, following these formulas:

- **Service line balancing:**
  Submitted line charge – Sum of service level RC amounts = Prov Pd (Calculated payment to provider)
- **Claim level balancing:**
  Billed (submitted claim level charge) – Sum of all service level RC amounts = Prov Pd (calculated payment to provider at the claim level)
- **Transaction level balancing:**
  Sum of all Prov Pd amounts in the claim segments – Total provider adj. = Amount of check

General SPR Completion Requirements

Field completion and calculation rules in the 835 also apply to the corresponding fields in the SPR, including the following:

- Any adjustment applied to the submitted charge and/or units will be reported in the claim and/or service adjustment segments with the appropriate group, reason, and remark codes explaining the adjustments. Every provider level adjustment will likewise be reported in the provider level adjustment section of the SPR.
- The computed field "Net" will include "Prov Pd" (Calculated Pmt to Provider, CLP04 in the 835) and interest, late filing charges, and previously paid.
- The first crossover carrier name on the SPR will be reported, even if coordination of benefits (COB) information is sent to more than one payer.
- The "amount of check" is the sum of all claim level payments less any provider level adjustments.
- Positive adjustment amounts reduce the amount of the payment and negative adjustment amounts increase it.
- An SPR will not be issued for a voided claim. An SPR will be issued for the adjusted claim with "Previously Paid" showing the amount paid for the voided claim.

[Reference: Change Request (CR) 1953; Transmittal B-01-76]

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Medical Policy

Got a question about Medical Policy? Don't forget to visit the DMERC A Web site at www.umd.nycpic.com/dmrmrpcopy.html for your answer...

Supplier Manual Policy Revisions

Revisions of the following local medical review policies (LMRPs) are available through the DMERC A Web site at **www.umd.nycpic.com/dmrmrpcopy.html**. The revisions include all changes to HCPCS codes and modifiers and any other information that has been included in bulletins since the LMRP was last published. A brief summary of the major changes in each LMRP is described. Suppliers are advised to review each LMRP for complete details.

Continuous Positive Airway Pressure Devices (*Effective for dates of service [DOS] on or after July 1, 2002*)

- Revised language regarding who is a qualified provider of polysomnographic studies [Please see related Web site posting at **www.tricenturion.com/content/new**]

Epoetin (*Effective for DOS on or after October 1, 2002*)

- Updated the target hematocrit range to 33 – 36% (this is already in effect)
- Added a requirement to use ICD-9 code V45.1 if the patient is on Method II home hemodialysis
- Replaced the ZX modifier with KX modifier. Even though the effective date of the LMRP revision is October 1, 2002, the KX modifier should be used in place of the ZX modifier (as described in the current LMRP) beginning with DOS on or after July 1, 2002.
- Effective for dates of service on or after October 1, 2002, required that KX modifier be used on every claim for Epoetin (EPO) if policy criteria are met
- Eliminated use of the EJ modifier with subsequent EPO claims

Facial Prosthesis (*Effective for DOS on or after July 1, 2002*)

- Added HCPCS codes A4364, A4365, K0572, K0573, and L8040-L8049
- Deleted HCPCS codes K0440-K0449, K0265, K0450, and K0451
- Added LT and RT modifiers
- Replaced Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) reference with paragraph referring to SADMERC Web site (**www.palmettogba.com**)

Immunosuppressive Drugs (*Effective for DOS on or after April 1, 2002*)

- Incorporated information from September 2001 *DMERC Medicare News* article about when a new DMERC Information Form (DIF) is not required

Negative Pressure Wound Therapy (*Effective for DOS on or after July 1, 2002*)

- Staging of Pressure ulcers revised under Definition section
- Coverage and Payment Rules Section E deleted, which is no longer applicable at this time
- Replaced SADMERC reference with paragraph referring to SADMERC Web site (**www.palmettogba.com**)
- Replaced ZX modifier with KX modifier

Orthopedic Footwear (*Effective for DOS on or after July 1, 2002*)

- Replaced ZX modifier with KX modifier
- Updated the HCPCS codes for therapeutic shoes for diabetics

Continued on next page...

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.

Osteogenesis Stimulators (*Effective for DOS on or after July 1, 2002*)
- Replaced ZX modifier with KX modifier
- Added SADMERC reference with paragraph referring to SADMERC Web site (**www.palmettogba.com**) under Coding Guidelines

Ostomy Supplies (*Effective for DOS on or after July 1, 2002*)
- Added HCPCS codes K0561-K0580
- HCPCS codes A4368, A4370, A4374, A4386, A5061, A5123, and A6265 became invalid for DMERC submission
- Definitions expanded to include new HCPCS code features
- Specific diagnoses for certain products removed from LMRP
- Billing instructions included, in Coverage and Payment Rules, when using K0561-K0580
- Usual Maximum Quantity of Supplies table updated and crosswalked to appropriate new HCPCS codes
- Replaced SADMERC reference with paragraph referring to SADMERC Web site (**www.palmettogba.com**)

Refractive Lenses (*Effective for DOS on or after July 1, 2002*)
- Replaced ZX modifier with KX modifier
- Added definition of progressive lenses (V2781)
- Removed requirement for UV lenses (V2755) to be justified by additional documentation
- Clarified when the RT and LT modifiers must be used
- Allows either a narrative diagnosis or ICD-9 diagnosis on the physician order

Pressure Reducing Support Surfaces-Group 1 (*Effective for DOS on or after July 1, 2002*)
- Replaced ZX modifier with KX modifier
- Replaced SADMERC reference with paragraph referring to SADMERC Web site (**www.palmettogba.com**)

Pressure Reducing Support Surfaces-Group 2 (*Effective for DOS on or after July 1, 2002*)
- Replaced ZX modifier with KX modifier, including all references in LMRP
- Replaced SADMERC reference with paragraph referring to SADMERC Web site (**www.palmettogba.com**)

Speech Generating Devices (*Effective for DOS on or after July 1, 2002*)
- Replaced ZX modifier with KX modifier
- Corrected typographical error in Coding Guidelines instructing the use of HCPCS code K0547 for mounting hardware instead of K0546

Walkers (*Effective for DOS on or after July 1, 2002*)
- Replaced ZX modifier with KX modifier
- Instructs suppliers to check the SADMERC Web site (**www.palmettogba.com**) to identify products that are correctly coded as E0147 and revises the documentation requirements for this code

If you do not have access to the Internet, you can request a hardcopy version of a specific LMRP by calling the Supplier Toll-Free Number at **866-419-9458** or by writing to:

HealthNow New York Inc.
Attention: Program Inquiries
P.O. Box 6800
Wilkes-Barre, PA
18773-6800

[Complete Internet address for SADMERC Web site: **www.palmettogba.com/palmetto/Other.nsf/Home/Other+Medicare+Partners+SADMERC+Home?OpenDocument**]

Specific Required Documentation on File

Effective for dates of service on or after July 1, 2002, use of the **KX** modifier constitutes a statement to the effect that suppliers actually have the documentation on file that the policy requires for the particular item or service.

[Reference: Change Request (CR) 2155; Transmittal B-02-026]

Correction – Commodes Policy

The recently revised Commodes local medical review policy (LMRP) inadvertently retained language in the Coding Guidelines section that should have been removed.

The sentence "Commode chairs that include seat lift mechanism features should be coded based upon the base commode chair features." should have been deleted.

We regret any confusion that may have been caused by this oversight. A correction to the policy has been posted to the DMERC A Web site at **www.umd.nycpic.com/dmrmrpcopy.html**.

Intrapulmonary Percussive Ventilation System – New Policy

A new local medical review policy (LMRP) on Intrapulmonary Percussive Ventilation Systems (IPV) has been finalized. This policy has been developed in conjunction with the establishment of a HCPCS code for this item, E0481 (Intrapulmonary percussive ventilation system and related accessories).

Pursuant to Medicare's National Coverage Determination at CIM 60-21 (Coverage Issues Manual, Section 60-21), this item is not covered.

[Reference: Change Request (CR) 1852; Transmittal AB-01-127]

♦**NOTE**:
A new format for LMRPs is being used with this issuance. All new policies will be written in this new format. Previously published policies will be transitioned to this format in the future. This new LMRP is available through the DMERC A Web site at **www.umd.nycpic.com/dmrmrpcopy.html**.

[Reference: Change Request (CR) 1859; Transmittal 14]

Abdominal Binders (A4462) vs. Abdominal Supports (L0900-L0960)

In the March 2002 edition of the *DMERC Medicare News*, notice was given of coverage for rib belts and "abdominal binders." The incorrect code (A4462) was listed for the items being referenced. A4462 (Abdominal dressing holder/binder, each) refers to binders that hold surgical dressings on an abdominal wound. The correct codes to bill for abdominal supports are L0900-L0960.

Coverage Issues Manual Update - Non-Contact Normothermic Wound Therapy (NNWT)

The *Coverage Issues Manual* has been updated with a new section, §60-25, to reflect a National Coverage Decision (NCD) on Non-Contact Normothermic Wound Therapy (NNWT). NNWT is a device reported to promote wound healing by warming a wound to a predetermined temperature. The device consists of a noncontact wound cover into which a flexible, battery powered, infrared heating card is inserted. New codes were issued for NNWT **effective for dates of service on or after January 1, 2002**:

E0231 Non-contact wound warming device (temperature control unit, AC adapter, and power cord) for use with warming card and wound cover.

E0232 Warming card for use with non-contact wound warming device and non-contact warming wound cover.

A6000 Non-contact wound warming cover for use with the non-contact warming device and warming card.

There is insufficient scientific or clinical evidence to consider this device as reasonable and necessary within the meaning of §1862(a)(1)(A) of the Social Security Act. Therefore, **effective for dates of service (DOS) on or after July 1, 2002**, NNWT will be denied as not medically necessary. Individual consideration will be applied to claims with DOS prior to July 1, 2002.

[Reference: Change Request (CR) 2027; Transmittal AB-02-025]

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CMN Effectiveness Study Underway

The Centers for Medicare & Medicaid Services (CMS) has implemented a study to evaluate the effectiveness of Certificates of Medical Necessity (CMNs) as a medical review screening tool. CMS selected TriCenturion, LLC, a Program Safeguard Contractor (PSC), to conduct this study.

TriCenturion will select a sample of CMN-related claims and perform an independent review of the medical record associated with these claims to corroborate the responses provided on the CMN. The study will compare the information contained in the medical records with the information included on the CMN. This will serve as the basis for measuring the accuracy of the CMN.

You may have already received an information request as part of this study. As with any study, participation is voluntary. However, the results of this study will impact the future use of the CMN. By participating in this study, you are contributing to the future direction of Medicare. CMS strongly encourages your cooperation in this study. Please provide the requested information as soon as possible to ensure timely completion of this study.

If you have any questions on this project, contact Joyce Graham at 803-264-7513.

Beneficiaries Previously Enrolled In Managed Care Who Return To Traditional Fee For Service

When a beneficiary who was previously enrolled in a Medicare HMO/Managed Care program returns to traditional Fee For Service (FFS), he or she is subject to all benefits, rules, requirements and coverage criteria as a beneficiary who has always been enrolled in FFS. When a beneficiary returns to FFS, it is as though he or she has become eligible for Medicare for the first time. Therefore, if a beneficiary received any items or services from their HMO or Managed Care plan, they may only continue to receive these items and services if they are entitled to them under Medicare FFS coverage criteria and documentation requirements.

For example, if a beneficiary received a manual wheelchair under their HMO/Managed Care plan, he or she would need to meet Medicare coverage criteria and documentation requirements for manual wheelchairs. A Certificate of Medical Necessity (CMN) would be required, and an entirely new rental period would begin, just as a beneficiary enrolled in FFS would to obtain a manual wheelchair for the first time.

There is an exception to this rule if a beneficiary was previously enrolled in FFS and received a capped rental item, then enrolled in an HMO, stayed with the HMO for 60 or fewer days, then returned to FFS. A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions may last up to 60 consecutive days plus the days remaining in the rental month in which use ceases, regardless of the reason the interruption occurs. Thus, if the interruption is less than 60 consecutive days plus the days remaining in the rental month in which use ceases, a new 15-month rental period will not begin. For purposes of this instruction, CMS has interpreted an end to medical necessity to include enrollment in an HMO for 60 or more days.

Another partial exception to this rule involves home oxygen claims. If a beneficiary was started on oxygen while under a Medicare HMO, when the beneficiary returns to FFS, the supplier must obtain an **initial** CMN and submit it to the DMERC at the time that FFS coverage begins. However, the beneficiary does not have to obtain the required blood gas study within 30 days prior to the initial date on the CMN. The test must be the most recent study the patient obtained while in the HMO, under the guidelines specified in DMERC policy. It is important to note that, just because a beneficiary qualified for oxygen under a Medicare HMO, it does not necessarily follow that he/she will qualify for oxygen under FFS.

These instructions apply whether a beneficiary voluntarily returns to FFS, or if he or she involuntarily returns to FFS because their HMO or Managed Care plan no longer participates in the Medicare+Choice program.

[Reference: Change Request (CR) 1966; Transmittal 1740]
[Reference: Change Request (CR) 2041; Transmittal 1742]

Miscellaneous

Written Requests for Review Submitted by a Supplier

Suppliers with appeal rights must submit written requests indicating what they are appealing and why. There are two acceptable written ways of doing this:

1. A completed Form HCFA-1964 (CMS-1964) constitutes a request for review. Completed means that all applicable spaces are filled out and all necessary attachments are attached.
2. A written request for appeal not on Form HCFA-1964 (CMS-1964) **must** contain the following information:
   - Beneficiary name;
   - Medicare health insurance claim (HIC) number;
   - Name and address of supplier of item;
   - Date of initial determination as reported on the Remittance Advice;
   - Date(s) of service for which the initial determination was issued (exact dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form);
   - Which item(s) are at issue in the appeal; and
   - Signature of the appellant.

When a Remittance Advice, which contains some of the required information, is attached, the claim(s) in question must be highlighted or emphasized in some manner.

If any of this information is not included, the appeal request will be returned with an explanation of what information is missing.

Address For Appeals

Effective May 9, 2002, mail for Appeals is being directed to an established, separate post office. Therefore, written requests for review should be mailed to:

HealthNow New York Inc.
P.O. Box 6300
Wilkes-Barre, PA
18773-6300

Appeal Rights on Non-Assigned Claims

Medicare guidelines state that suppliers may have appeal rights depending upon, in most instances, whether the claim is submitted as assigned or non-assigned. Instances where a supplier may have appeal rights are as follows:

- A participating supplier who accepts assignment;
- A nonparticipating supplier who accepted assignment on the claim(s) in question;
- A nonparticipating supplier who does not accept assignment on claim(s) to a beneficiary and who may potentially be responsible for making a refund to the beneficiary.

Suppliers may be appointed as a representative by the beneficiary. Form HCFA-1696-U4 (CMS-1696-U4) can be used to appoint a representative or a written statement with the following elements:

- Name/Address/Phone Number of the beneficiary;
- Health Insurance Claim Number;
- Name/Address/Phone Number of the individual being appointed as representative;
- A statement that the beneficiary is authorizing the representative to act on her or his behalf for the claim(s) at issue and a statement authorizing disclosure of individually identifying information to the supplier;
- Signature of the beneficiary making the appointment and the date signed; and
- Signature of the individual being appointed as representative, accompanied by a statement that he/she accepts the appointment and the date signed.

When an request for a review from the supplier is received on a non-assigned claim, if no authorization is included, then you cannot be considered as a party to an appeal; therefore, no appeal rights are afforded and we are required to reject your request for a review.

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Appeal Rights on Claims Denied as Duplicate

Medicare guidelines state that appeal rights should be afforded to the initial determination only. An initial determination is the first adjudication (judgement) made by Medicare following a request for Medicare payment for claims. A Remittance Advice notifies the supplier of an initial determination and provides appropriate appeals information. Claims that are denied as duplicate (including claims that have been previously paid or denied) should not be afforded appeal rights.

Therefore, when a request for a review is received on a claim that is denied as a duplicate, no appeal rights are afforded and we are required to reject your request for a review. No further appeal rights are afforded on these claims.

Please keep in mind that according to Medicare guidelines, a request for a review must be filed within six (6) months of the initial determination date as listed on the Remittance Advice. If the appeal is not filed within the six (6) months of the initial determination date, then the review will be dismissed as untimely.

Aggregating Claims

Remember, if you wish to request a Hearing Officer hearing by combining the several reviews to meet the amounts in controversy then:

- EACH CLAIM included in your request for Hearing Officer hearing must be appealed within six (6) months from the date the review determination was issued on the claim, and each claim must have already received a review determination; AND
- You MUST clearly state on your request for Hearing Officer hearing that you are "aggregating claims;" AND
- You must list the specific claims that you are aggregating.

If you do not clearly state on your request for Hearing Officer hearing that you are aggregating claims, then each claim will be treated as an individual request for a hearing and those claims that do not meet the amount in controversy will be dismissed.

B4155 Fee Update

The Region A DMERC has noted an error in the reimbursement amount for code B4155, Enteral formula; category V; modular components, administered through an enteral feeding tube, 100 calories = 1 unit. The fee for years 1997 through 2001 was $0.89. The correct fee is $0.87, effective immediately.

No adjustments will be made to previously processed claims.

Ostomy Code Fees

The below fees were effective April 1, 2002:

Code	Fee	Code	Fee
K0561	$3.36	K0571	$5.93
K0562	$5.68	K0572	$0.09
K0563	$8.91	K0573	$0.36
K0564	*IC	K0574	$0.46
K0565	$6.15	K0575	$0.28
K0566	$8.94	K0576	$0.28
K0567	$2.57	K0577	$0.28
K0568	$3.74	K0578	$0.53
K0569	$5.44	K0579	$0.12
K0570	$4.89	K0580	$0.35

*(*IC - Individual Consideration)*

The above HCPCS codes are new codes effective with dates of service on or after April 1, 2002.

For claims **received** April 1st through April 11th, 2002, the ostomy code allowables paid out were inconsistent with the above. The codes affected were K0561, K0562, K0565, K0566, K0567, K0568, K0569, K0570, K0571, K0572, K0573, K0574 & K0580. We are in the process of adjusting all claims affected.

[Reference: Change Request (CR) 1952; Transmittal AB-01-178]

Correction - 2002 Fee Schedule

The following TLSO code fees were corrected in our system on May 16, 2002. Claims processed or adjusted on or after this date will be processed using these new fees. The corrected fee schedule amounts are listed below:

Code	Fee
L0321	$425.31
L0331	$494.27
L0391	$620.05

Notification of Updates to Coding Files on CMS Web Site for Skilled Nursing Facility (SNF) Consolidated Billing (CB)

The SNF CB coding files on the CMS Web site at **www.hcfa.gov/medlearn/refsnf.htm** have been updated to reflect a number of corrections and policy changes. These code changes will be effective with the April 2002 implementation of CR 1764, Program Memorandum (PM) AB-01-159, dated November 1, 2001, *Common Working File (CWF) Reject and Utilization Edits and Carrier Resolution for Consolidated Billing for SNF Residents*, which implements the CWF edits. Effective April 1, 2002, CWF will have updated its edit files to reflect these changes.

[Reference: Change Request (CR) 2085; Transmittal AB-02-035]

Electronic Medicare Provider/Supplier Enrollment Forms

Electronic versions of the Medicare provider/supplier enrollment forms are available on the Centers for Medicare & Medicaid Services (CMS) Web site at **http://www.hcfa.gov/medicare/enrollment/forms/**. These forms include the HCFA 855A, HCFA 855B, HCFA 855I, HCFA 855R and HCFA 855S (CMS 855A, CMS 855B, CMS 855I, CMS 855R and CMS 855S). A comprehensive user guide, providing detailed instructions on how to download these applications, is also available on the web site. Providers/suppliers can complete a form on their computer, save it as a file, and print the completed form for final signature and submission. These forms cannot be submitted electronically at this time.

Providers/suppliers should direct any questions regarding these forms to the National Supplier Clearinghouse at **(866) 238-9652** or by writing:

National Supplier Clearinghouse
Palmetto GBA
P.O. Box 100142
Columbia, SC 29201-3142

[Reference: Change Request (CR) 2045; Transmittal AB-02-029]

New Source of Provider Information to be Available on CMS Web site April 22, 2002

The Centers for Medicare & Medicaid Services (CMS) released the first issue of *The CMS Quarterly Provider Update* on April 22, 2002. Future issues will be released the first work day of each subsequent calendar quarter. These quarterly Updates will include all changes to Medicare instructions that affect providers, or may be of interest to them. They will provide a single source for national Medicare provider information and give providers advance notice on upcoming instructions and regulations.

The first release is a Web-based document and is available at **www.cms.hhs.gov/providerupdate**. For ease of use by individual providers, regulations and instructions are collated and sorted based on the interests of the user.

Each Update will include the full text of instructions to be implemented 90 or more days after its release. For example, instructions included in the April Update will have an implementation date of July 1, 2002 or later. The listings of regulations will be presented into two parts. One part will list all regulations CMS plans to publish within the next 90 days. The second part will include hyperlinks to the text of all regulations published in the previous quarter.

CMS' goal is to make it easier for providers to understand and comply with Medicare regulations and instructions and to give them time to review and react to upcoming program changes. To improve future issues of the Update and ensure they are responsive to provider needs, a feedback form will be included with each issue. CMS encourages anyone accessing the Update to use the feedback form to forward comments on its utility, organization and format.

[Reference: Change Request (CR) 1868; Transmittal AB-01-134]

Change Requests On The Internet

Article references can be found at these Web sites:

- **www.hcfa.gov/pubforms/transmit/memos**; or
- **www.hcfa.gov/pubforms/transmit/transmittals**.

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Program Education & Training

The Region A DMERC Provider Education & Training Advisory Group

One of the primary responsibilities of Program Education & Training (PET) is to assure that suppliers are fully knowledgeable about Medicare provisions and the proper claim submission requirements. Each fiscal year, the expectations of the Centers for Medicare & Medicaid Services (CMS) relative to the educational responsibilities of PET are clearly addressed in the DMERC Statement of Work. In conjunction with the Statement of Work, Budget and Performance Requirements are also developed by CMS, which outline DMERC initiatives established to achieve the goal of providing superior customer service while protecting the integrity and promoting the success of the Medicare Trust Fund.

One of these iniatives is the establishment of a Provider Education and Training Advisory Group (PETAG). The purpose of the PETAG is for members of the supplier community to interact directly with DMERC and CMS staff to discuss current trends and global concerns within the industry. Members are asked to provide advice and recommendations for the selection of provider education and training topics, as well as avenues, types, and locations for educational forums to address these concerns.

The current PETAG member roster includes a myriad of representatives from state medical societies, state supplier associations, manufacturers, billing services, and supplier organizations within the Region A DMERC service area; such as, the New York Medical Equipment Dealers Association (NYMEP), the Jersey Association of Medical Equipment Suppliers (JAMES), the Pennsylvania Association of Medical Suppliers (PAMS), the Pennsylvania Orthotics & Prosthetics Society (POPS), and the American Orthotics & Prosthetics Association (AOPA). All have come aboard to assist and advise the DMERC on global issues that suppliers are experiencing within the DME industry.

PETAG meetings occur on a quarterly basis with the location rotating througout the Region A territory. Meetings thus far have taken place on October 12, 2001 and January 9, 2002 in Philadelphia, PA and on March 13, 2002 in Scranton, PA. Future meetings are scheduled for June and September, with a tentative location to include the New England area. The meetings generally consist of a morning DMERC session that includes DMERC updates, an educational forum and an open discussion related to provider education. The afternoon session has typically been held by TriCenturion, LLC, the Program Safeguard Contractor for the Region A DMERC. Some of the featured topics presented at the past meetings have included data analysis information and its many uses by PET for educational initiatives (e.g., charts/graphs on the top five claim denials, top five procedure codes billed, state by state listings of new and active providers, etc.) provided to PET by our Data and Practice Analysis (DAPA) Department; discussions involving CMS on issues submitted by various PETAG members, and a "Meet with your Ombudsman" session. The educational forums have also addressed "hot topic issues"; such as, the Health Insurance Portability and Accountability Act (HIPAA) and other DMERC-specific presentations pertaining to the DMERC A Web site and anticipated Interactive Voice Response (IVR) system.

The Program Education & Training (PET) Team encourages any and all other interested representatives to become a member of the PETAG. It is important to us to ensure that our targeted educational efforts are both meaningful and helpful to the supplier community as a whole. If you would like more information regarding the PETAG, or if you wish to become a member, please contact Amy Capece, Manager, PET at 570-735-9509 or Mary Jo George-Roue, Service Plan Specialist, PET at 570-735-9656.

***REGION A DMERC PETAG MISSION STATEMENT*:**

- In partnership, we define effective educational forums for the Region A provider community.
- Together we will address the educational needs of providers through regular briefings, recommendations and requests from the provider community and through assessment of DMERC tracking initiatives.
- We do this with the support of the Centers for Medicare & Medicaid Services (CMS) in order to assure that providers are fully knowledgeable about Medicare provisions.

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.

Claim Submission Errors

As part of the reporting requirements by the Centers for Medicare & Medicaid Services (CMS), the Region A DMERC must tally and analyze data related to Claim Submission Errors (CSEs). Claim Submission Errors are errors made on a claim form that would cause the claim to reject upon submission to the DMERC. The Data and Practice Analysis (DAPA) Team at the DMERC has performed an analysis related to the Top Ten Claim Submission Errors for the Region A DMERC for the second quarter of fiscal year 2002, which runs from January 1, 2002 to March 31, 2002. During this timeframe there were **44,997** errors on claims submitted to the DMERC A. The top ten errors are listed below, followed by an explanation of each error and what information is needed to eliminate these errors. Please take a minute to read more about them.

- **1.) Error:** Diagnosis code 1 is blank. This is Block 21 of the HCFA-1500 (CMS-1500) claim form and the EA0-32 record of the electronic claim. **Correction:** Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity. You may enter up to four codes in priority order (primary, secondary condition). All narrative diagnosis for non-physician specialties must be written on the claim form or entered in the HA0 record of the electronic claim. **Number of Errors:** There were 15,162 claims submitted without a diagnosis on the claim.

- **2.) Error:** Insured's ID number is invalid. This is Block 1A of the HCFA-1500 (CMS-1500) claim form and the DA0-18 record of the electronic claim. **Correction:** Enter the patient's Medicare Health Insurance Number (HICN), whether Medicare is the primary or secondary insurer. **Number of Errors:** There were 5,044 claims submitted without the patient's HICN number.

- **3.) Error:** Referring physician's UPIN is missing. This is Block 17A of the HCFA-1500 (CMS-1500) claim form and the FB1-9 record of the electronic claim. **Correction:** Enter the physician UPIN number, a letter followed by five digits. You can obtain a copy of all UPINs from local Part B Medicare Offices or our Web site, **www.umd.nycpic.com/dmrprovinfo.html** (UPIN Directory link). **Number of Errors:** There were 4,354 claims submitted without the physician's UPIN number.

- **4.)** and **5.) Error:** Part of the Other Carriers Name and Address (OCNA) number is missing or invalid. This is Blocks 9 and 11 of the HCFA-1500 (CMS-1500) claim form and the DA0-7 and DA0-8 records of the electronic claim. **Correction:** Enter the nine-digit OCNA number. This is used for a secondary insurance crossover. The OCNA number can be found on our Web site, **www.umd.nycpic.com/OCNA_01-02.html**. **Number of Errors:** There were 4, 207 claims submitted without the OCNA number.

- **6.) Error:** Duplicate claim file submission. The provider sends in the same electronic file prior to receiving the explanation of why the file was rejected for the first submission. **Correction:** The "Create Date" and "Submission Number" on the electronic file must be changed before resubmission. **Number of Errors:** There were 2, 689 duplicate claims submitted.

- **7.) Error:** Invalid service dates. These dates are found in Block 24A of the HCFA-1500 (CMS-1500) claim form and the FA0-6 record of the electronic claim. **Correction:** Enter the precise eight-digit dates (MMDDCCYY) for each procedure, service, or supply. **Number of Errors:** There were 2,514 claims rejected because of inaccurate service dates.

- **8.) Error:** Service "from" and "to" dates cannot span years. These dates are found in Block 24A of the HCFA-1500 (CMS-1500) claim form and the FA0-605 record of the electronic claim. **Correction:** Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in Column G. **Number of Errors:** There were 2,355 claims submitted with incorrect "from" and "to" dates.

- **9.) Error:** Beneficiary's address is invalid. This is Block 5 of the HCFA-1500 (CMS-1500) claim form and the CA0-12, Line 2, record of the electronic claim. **Correction:** Enter the patient's precise mailing address. For the claim form: Enter the complete street address on the first line in Block 5. For the electronic claim: On the first line enter the street address; the second line, issued to suite or apartment, room, floor, and it must have an embedded space (i.e. APT_4). **Number of Errors:** There were 2,253 claims submitted with incorrect Beneficiary addresses.

- **10.) Error:** Beneficiary's zip code is invalid. This is Block 5 of the HCFA-1500 (CMS-1500) claim form and the CA0-16 record of the electronic claim. **Correction:** Enter the patient's precise zip code. For the claim form: Enter the zip code on the third line in Block 5. For the electronic claim: Enter the zip code in the CA0-16 record. **Number of Errors:** There were 2,223 claims submitted without the proper Beneficiary zip code.

Let's make it our goal to reduce the number of erroneous claims by taking an extra minute, for you and your staff, to review your claims before submission to insure that all the required information is on the claim. We'll keep providing information to assist you in reducing these errors so that both the DMERC and Region A Providers can benefit. Please take advantage of this information and share it with your colleagues!

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.

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, changed, or incorporated within articles published in this edition of the DMERC Medicare News.

Recently Published Supplier Notices

The following Supplier Notices have been published since the last edition of the *DMERC Medicare News* (No. 61, March 2002):

- **Supplier Notice 2002-09 (March 27, 2002)**
  Oxygen Coverage for Beneficiaries Previously Enrolled In Managed Care Who Transition to Traditional Fee For Service (FFS)

- **Supplier Notice 2002-10 (March 27, 2002)**
  Billing Reminder: Ostomy Supplies

- **Supplier Notice 2002-11 (March 28, 2002)**
  ATTENTION: ACCELERATE USERS

- **Supplier Notice 2002-12 (April 12, 2002)**
  ATTENTION: VPIQ Users

- **Supplier Notice 2002-13 (April 19, 2002)**
  Fee Schedule Updates

To view these notices, visit the DMERC A Web site at **www.umd.nycpic.com**, and click on "Suppliers", then "Alerts and Notices" [**www.umd.nycpic.com/alerts_notice.html**]. If you do not have access to the Internet, you can request a hardcopy version of a specific notice by calling the Supplier Toll-Free Number at **866-419-9458** or by writing to:

HealthNow New York Inc.
Attention: Program Inquiries
P.O. Box 6800
Wilkes-Barre, PA
18773-6800

[Reminder: Requests for specific fee schedules or fee schedule updates are sent "Attention: FOIA"]

NOTE: Effective April 29, 2002, the DMERC A will issue Supplier Notices solely under critical (and therefore limited) circumstances (i.e. building closure, CMS-mandated immediate publication, etc.). All other information will be held for the next bulletin, or in special circumstances be posted to our Web site, with references in subsequent newsletters. Therefore, suppliers are encouraged to visit the DMERC A Web site, and to subscribe to our ListServe, for their informational needs.

Looking For Better Ways To Serve You

Want to know when updates are made to the DMERC A Web site? Subscribe to our ListServe, at www.umd.nycpic.com/dmlistserve.html, and stay in the know...

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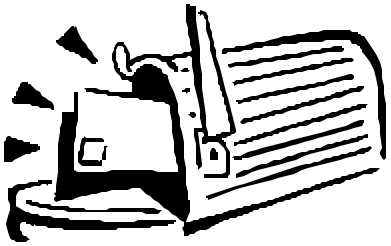
HIPAA Changes

Don't get left behind; get all the up-to-date facts on the changing HIPAA information on our Web site at **www.umd.nycpic.com**. Click on "DMERC," click on "EDI" and click on the new "EDI & HIPAA" link. [**www.umd.nycpic.com/emc&hipaa.html**]



Did You Recently Move or Have a Change of Address?

Suppliers that move or have a change of address ***must*** inform the National Supplier Clearinghouse (NSC) of their new address(es) and telephone number(s), including area code changes. If the NSC is not notified, Medicare payments and mailings will not be sent to the correct address(es). The DMERC A will notify the NSC if a check or Remittance Advice is returned due to an incorrect address, and will hold all payments and mailings until the NSC confirms the supplier provided the correct address(es) and their file is updated. Please contact the NSC toll-free at telephone number **866-238-9652** for information on how to update your address.

[Reference: Change Request (CR) 2038; Transmittal B-02-023]

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.