DMERC
Medicare
News

DMERC A Service Office ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800 ◆ Phone 866-419-9458 ◆ www.umd.nycpic.com
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Spring 2002 Supplier Education Events

The DMERC A announces the Spring 2002 continuing education seminars and workshops. Topics for the sessions include: DMERC 101, Documentation/Certificates of Medical Necessity (CMNs), CMS Change Requests, Respiratory, Specialized DME, Parenteral and Enteral Nutrition, and Orthotics and Prosthetics. Continental breakfast and workshop materials will be provided. The workshops are being offered as two-day sessions; however, you may attend both days or one day only.

Dates and Locations

Seminars: DMERC 101 (one-day session)

April 8	Holiday Inn Turf	205 Wolf Rd.	Albany, NY	518-458-7264
April 17	Lackawanna Visitors Center	235 Montage Mtn. Rd.	Scranton, PA	570-963-6441

Workshops (two-day sessions)

April 22-23	Radisson Pittsburgh	101 Mall Blvd.	Monroeville, PA	412-373-7300
May 1-2	Marriott LaGuardia	102-05 Ditmars Blvd.	East Elmhurst, NY	718-565-8900
May 21-22	Resorts Atlantic City	1133 Boardwalk	Atlantic City, NJ	609-344-6000
June 5-6	Holiday Inn	172 N. Main St.	Concord, NH	603-224-9534

Additional dates and locations to be announced for the Boston area. Please visit our Web site at *www..umd.nycpic.com* or call 570-735-9406 for more information.

DMERC 101 Seminar Agenda:

8:30 AM - 9:00 AM	Registration	12:00 PM - 1:00 PM	Lunch (on your own)
9:00 AM - 12:00 PM	DMERC 101	1:00 PM - 4:00 PM	DMERC 101 (cont.)/ CMS Change Requests

Workshop Agenda - Day 1:

8:30 AM - 9:00 AM	Registration	12:00 PM - 1:00 PM	Lunch (on your own)
9:00 AM - 12:00 PM	Documentation/CMNs	1:00 PM - 4:00 PM	Documentation/CMNs (cont.)/ CMS Change Requests

Workshop Agenda - Day 2:

8:30 AM - 9:00 AM	Registration
9:00 AM - 12:00 PM	Respiratory OR Parenteral and Enteral Nutrition (AM Session)
12:00 PM - 1:00 PM	Lunch (on your own)
1:00 PM - 4:00 PM	Specialized DME (includes Ostomy, Urological Supplies, and Surgical Dressings) OR Orthotics and Prosthetics (PM Session)

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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

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.

How to Register

All attendees must be registered in advance. The registration fee for the DMERC 101 session is $25. The registration fee for the workshops is $25 per day or $45 for both days. Complete the form below or print the online form from our Web site. The completed form must be mailed with payment and postmarked on or before the noted deadline dates. **Credit cards and cash are not accepted.** Make checks payable to HealthNow New York Inc., and mail the form and check to the address listed below. Registrations **will not** be accepted by telephone. **The registration fee is non-refundable.** Due to limited space, registration is on a first-come, first-served basis. In the event that a particular session is filled to capacity, you will be notified by telephone. The DMERC reserves the right to cancel any seminar. If this occurs, you will be notified and your registration fee will be refunded. **Note:** If you do not receive your confirmation within 5 days of the event for which you have registered, please call the Program Education & Training department at 570-735-9406. **Please contact the hotels directly for information regarding overnight accommodations, parking and driving directions.**

Complete a registration form for each person attending. Please type or print clearly.

Company Name: _____ Supplier Number: _____

Address: _____

Phone Number: _____ Fax Number: _____

Name of Attendee: _____ Contact Name: _____

***** Check the date(s) and seminar/workshop(s) you wish to attend *****

Seminars:

❑ **DMERC 101 - April 8, 2002, Albany, NY**
Registration Deadline - April 2, 2002

❑ **DMERC 101 - April 17, 2002, Scranton, PA**
Registration Deadline - April 9, 2002

Workshops:

❑ **Documentation/CMNs - April 22, 2002, Monroeville, PA** ---- ***Registration Deadline - April 15, 2002***

April 23, 2002, Monroeville, PA ---- ***Registration Deadline - April 15, 2002***

AM Session (Check One)
❑ Respiratory ❑ Parenteral and Enteral Nutrition

PM Session (Check One)
❑ Specialized DME ❑ Orthotics and Prosthetics

❑ **Documentation/CMNs - May 1, 2002, East Elmhurst, NY** ---- ***Registration Deadline - April 23, 2002***

May 2, 2002, East Elmhurst, NY ---- ***Registration Deadline - April 23, 2002***

AM Session (Check One)
❑ Respiratory ❑ Parenteral and Enteral Nutrition

PM Session (Check One)
❑ Specialized DME ❑ Orthotics and Prosthetics

❑ **Documentation/CMNs - May 21, 2002, Atlantic City, NJ** ---- ***Registration Deadline - May 13, 2002***

May 22, 2002, Atlantic City, NJ ---- ***Registration Deadline - May 13, 2002***

AM Session (Check One)
❑ Respiratory ❑ Parenteral and Enteral Nutrition

PM Session (Check One)
❑ Specialized DME ❑ Orthotics and Prosthetics

❑ **Documentation/CMNs - June 5, 2002, Concord, NH** ---- ***Registration Deadline - May 31, 2002***

June 6, 2002, Concord, NH ---- ***Registration Deadline - May 31, 2002***

AM Session (Check One)
❑ Respiratory ❑ Parenteral and Enteral Nutrition

PM Session (Check One)
❑ Specialized DME ❑ Orthotics and Prosthetics

Mail your registration and check to:
HealthNow New York, Inc., Attn: Seminar Registration, P.O. Box 6800, Wilkes-Barre, PA, 18773-6800

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Billing

Correction - Billing for Partial Month Rental Items

A previously published article in the December 2001 edition of the *DMERC Medicare News* instructed suppliers to enter "from" and "to" dates on the HCFA-1500 form when billing for a partial month's rental. This information was incorrect; suppliers should **not** enter the "from" and "to" dates on the HCFA 1500 form when billing for partial month rental items.

However, as previously published, the KR modifier must be used. Effective for dates of service on or after April 1, 2002, the new modifier was established:

KR Rental Item - billing for partial month

The KR modifier is for use by suppliers who wish to bill for partial months of rental on durable medical equipment (DME) items in the capped rental payment category.

Billing for Blood Glucose Test Strips and Supplies

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 October 1, 2001. 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 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.

Preferred Billing Procedures and Reminders for DMEPOS

Below are some preferred billing procedures and reminders for suppliers submitting claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to Medicare.

- Suppliers should submit their claims on a monthly basis. Suppliers should bill no more or less frequently than monthly, for a month's worth of DMEPOS, unless another policy that allows billing at a different frequency applies (e.g., blood glucose test strips).
- For items or services a supplier furnishes over an extended period (e.g., capped rental equipment or therapies), suppliers should bill their claims in sequence for each beneficiary. When there is a break in service (e.g., interruption of capped rental or outpatient therapies as the result of an extensive inpatient stay), suppliers should continue sequential billing when the services resume.
- DMEPOS cannot be automatically mailed to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS. The Medicare program advises beneficiaries to report any instances of fraudulent or abusive practices, such as excessive or non-requested deliveries of test strips, to their Durable Medical Equipment Regional Carrier. Please remember that beneficiaries must specifically request refills of supplies before they are dispensed.

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.

Capped Rental Equipment

The following information is being supplied as a reminder when supplying capped rental equipment. These guidelines apply to all capped rental equipment, new or used.

The Medicare Carriers Manual Section 5102.1(E) states in part:

Capped Rental Items - *For these items of DME, pay on a monthly rental basis not to exceed a period of continuous use of 15 months or on a purchase option basis not to exceed a period of continuous use of 13 months.*

In reference to the above, Medicare will only allow a capped rental item if it is rented and meets criteria. Suppliers should only be renting these items (please note that power wheelchairs and ultralightweight wheelchairs can be supplied as either a purchase or capped rental item). In the tenth month of rental, the rent/purchase letter should be sent to the beneficiary asking if they wish to purchase or continue to rent the equipment. If the beneficiary elects to purchase, Medicare will allow up to 13 months of rental and the patient would be responsible for any repairs. If the beneficiary elects to continue to rent, Medicare will allow up to 15 months rental. The supplier may then bill Medicare for the maintenance and service after six months have passed from the end of the final paid rental. This is payable twice a year whether or not the equipment is actually serviced.

Suppliers must inform the beneficiary that Medicare will not pay for the purchase of a capped rental item. If the beneficiary insists on purchasing the capped rental item outright, we suggest that the supplier have the beneficiary sign a statement informing them that the beneficiary will be responsible for the purchase and will not receive Medicare reimbursement.

New End Stage Renal Disease (ESRD) Billing Procedures

Method II ESRD suppliers must maintain documentation to support the existence of a written agreement with a Medicare certified support service facility within a reasonable distance from the beneficiary's home. Effective July 1, 2002, suppliers must use the KX modifier on the line item level for all Method II home dialysis claims to indicate that they have this documentation on file, and must provide it to the DMERC upon request. As of July 1, 2002, DMERCs will reject any Method II claims that do not have the KX modifier at the line item level. The supplier may correct and resubmit the claim with the appropriate modifier.

Deceased Physician UPINs

Section 1833(q) of the Social Security Act requires that all physicians that meet the Section 1861(r) definition of a physician must have a UPIN and all claims for services ordered or referred by one of these physicians include the names and UPINs of the ordering/referring physicians.

Durable medical equipment, prosthetics, and orthotics supplies require UPINs. Furthermore, claims for supplies ordered by non-physician practitioners or other limited licensed practitioners must include the UPIN of the supervising physician.

Beginning April 1, 2002, assigned claims with invalid or deceased ordering/referring physicians' UPINs, or claims whose dates of service exceed the physicians' date of death, will be denied. These denials will be based on medical necessity. Maintenance, service, and repair codes will be excluded from these denials. The DMERC may request additional information in order to process an unassigned claim. A new Certificate of Medical Necessity (CMN) will be needed after 15 months from the date of the ordering/referring physicians' death.

New Ostomy Codes as of April 1, 2002

Several ostomy codes have been made not valid for submission to the DMERC, while many new codes become effective with dates of service on or after April 1, 2002. As explained below, some of these new codes represent add-on features which may be billed separately.

Codes not valid for submission to the DMERC on or after April 1, 2002:

A4368 Ostomy filter, any type, each
A4370 Ostomy skin barrier, paste, per oz.
A4374 Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, with built-in convexity, any size, each
A4386 Ostomy skin barrier, with flange (solid, flexible or accordion), extended wear, without built-in convexity, any size, each
A5061 Pouch, drainable; with barrier attached (1 piece)
A5123 Skin barrier; with flange (solid, flexible, or accordion), any size, each
A6265 Tape, all types, per 18 square inches

New codes effective with dates of service on or after April 1, 2002:

K0561 Ostomy skin barrier, non-pectin based, paste, per ounce
K0562 Ostomy skin barrier, pectin-based, paste, per ounce
K0563 Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each
K0564 Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each
K0565 Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each
K0566 Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each
K0567 Ostomy pouch, drainable, with karaya based barrier attached, without built-in convexity, (1 piece), each
K0568 Ostomy pouch, drainable, with standard wear barrier attached, without built-in convexity, (1 piece), each
K0569 Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), each
K0570 Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4 x 4 inches or smaller, each
K0571 Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 inches, each
K0572 Tape, non-waterproof, per 18 square inches
K0573 Tape, waterproof, per 18 square inches
K0574 Addition to ostomy pouch, filter, integral or added separately to pouch, each
K0575 Addition to ostomy pouch, rustle-free material, per pouch
K0576 Addition to ostomy pouch, friction and irritant-reducing, absorbent, interface layer (comfort panel), per pouch
K0577 Addition to ostomy pouch, odor barrier, incorporated into pouch laminate, per pouch
K0578 Addition to ostomy pouch, faucet-type tap with valve for draining urinary pouch, each
K0579 Addition to ostomy pouch, absorbent material (sheet/pad/crystal packet) to thicken liquid stomal output, for use in pouch, each
K0580 Addition to ostomy pouch, flange locking mechanism, each

Definitions of New Codes:
The following are revisions or additions to definitions, found in the local medical review policy (LMRP) for Ostomy Supplies in the Supplier Manual, in reference to the new codes.

Barriers:
A solid barrier (wafer) is an interface between the patient's skin and the pouching system, has measurable thickness and has an adhesive property. Barriers may be integrated into a "1 piece" pouch; they may be manufactured with a flange and be part of a "2 piece" pouch system (skin barrier with flange; e.g., K0570); or they may be used independently (e.g., A4362), usually with a pouch that does not have its own integral skin barrier. When barriers are used as part of a "1 piece" drainable pouch, they may be either pectin-based (e.g., K0568) or karaya-based (e.g., K0567). An extended wear barrier (e.g., K0565) is a pectin-based barrier with special additives which achieve a stronger adhesive seal, resist breakdown by urine or bowel effluent, permit longer wear times between changes, and normal wear times for those who cannot achieve them with standard barriers. There are distinct codes for extended wear compared to standard wear barriers.

A barrier with built-in convexity (e.g., K0563) is one in which an outward curve is usually achieved with plastic embedded in the barrier, allowing better protrusion of the stoma and adherence to the skin. There are distinct codes for barriers with built-in convexity compared to flat barriers.

Ostomy skin barriers greater than 4 x 4 inches (K0564, K0566, K0571) refer to the size of the skin barriers themselves, and not to the area of any surrounding tape.

Pouches:
A "high output" pouch (K0569) has a capacity of greater than or equal to 0.75 liters, an anti-reflux valve, a large-bore, solid spout with cap or plug, and is part of a 2-piece system.

Add-on Features to Pouches:
Filters (K0574) allow venting of gas trapped in the ostomy pouch. They may also include materials such as charcoal to deodorize the vented gas. Filters may be incorporated into the pouch, inserted into a venting ring on the pouch, or attached to the pouch exterior.

Rustle-free material (K0575) reduces the crackling noise produced by pouch materials with bodily movement.

Friction and irritant-reducing, absorbent, interface layer (comfort panel) (K0576) is a soft material layer on the body side of the pouch that reduces skin irritation, sticking and sweating that would otherwise result from direct contact of the pouch with the skin.

An odor barrier (K0577) is a film layer (e.g., polyvinyl dichloride) incorporated into the pouch, which serves to retain odor within the pouch. It is separate from any odor absorbing material contained in a pouch filter (K0574).

A faucet-type tap (K0578) with a valve for draining urinary pouches (A4391, A4392, A4393, A5071, A5072, A5073) is distinguished from plugs, caps, fold-up or clip-type drainage closures.

Absorbent material (K0579) may come as sheets, pads or crystals, that is added to the ostomy pouch.

Code K0580 describes a lever-type flange locking mechanism. It differs from simple push-on pouch securing mechanisms. The mechanism may be incorporated either in the pouch flange or skin barrier flange.

Pastes:
A paste is used as a protective layer and sealant beneath ostomy appliances, and is applied directly on the skin. It may be primarily pectin-based (K0562), or non-pectin based, e.g., karaya (K0561).

Additional Allowances for Certain Codes:
When supplied with a covered ostomy pouch, codes K0574-K0580 are paid separately and in addition to the ostomy pouch codes, for which these K codes represent add-on features. They should be billed on separate claim lines, in addition to the pouch code, when they represent additional features of that pouch.

For codes K0575, K0576, K0577, K0578, and K0580, only one unit of each code per pouch may be billed.

Usual Maximum Quantities of New Codes:
Only those new codes that are direct analogues (crosswalks) of eliminated codes, for which maximum quantities had been listed in the table in the Ostomy Supplies LMRP, are listed below:

K0567 and K0568 replace A5061; the usual maximum allowable quantity remains 20 units per month
K0570 and K0571 replace A5123; the usual maximum allowable quantity remains 20 units per month
K0572 and K0573 replace A6265; the usual maximum allowable quantity remains 40 units per month
K0561 and K0562 replace A4370; the usual maximum allowable quantity remains 4 units per month

An order from the treating physician must specify the quantity of ostomy supplies required by a beneficiary, and if greater than the usual maximum quantity of supplies per month stated in the LMRP are needed, this should be specified on the order and the reasons for the increased need documented in the patient's medical record. The add-on codes (K0574-K0580) do not need to be specifically listed on the physician's order.

Under the standard grace period, the invalid HCPCS codes will continue to be accepted on claims for dates of service on or after April 1, 2002, that are received by June 30, 2002. However, use of the invalid codes for dates of service on or after April 1, 2002, received on claims on or after July 1, 2002, will be denied as incorrect coding.

The Ostomy Supplies LMRP will be revised and published at a later date to incorporate these changes.

Tape – Code Changes

Two new codes have been established for tape:

K0572 Tape, non-waterproof, per 18 square inches
K0573 Tape, waterproof, per 18 square inches

These codes are effective for dates of service on or after April 1, 2002. The current code for tape, A6265 (tape, all types, per 18 square inches), has been made invalid for claim submission to the DMERC for dates of service on or after April 1, 2002. Under the standard grace period, code A6265 will continue to be accepted on claims with dates of service on or after April 1, 2002, that are received by June 30, 2002. Claim lines with code A6265 with dates of service on or after April 1, 2002, that are received on or after July 1, 2002, will be rejected as invalid coding. Code A6265 will continue to be valid for claims with dates of service on or before March 31, 2002, regardless of the date that the claim is received.

This code change applies to use of the tape code in all situations, including the following local medical review policies: Facial Prostheses, Ostomy Supplies, Surgical Dressings, and Urological Supplies.

New Permanent Modifier - KX

Effective for dates of service on or after July 1, 2002, a new Level II national modifier has been created:

KX - Specific Required Documentation on File

The KX modifier will replace the local modifier ZX currently used in local medical review policies (LMRPs). The new modifier is required when a LMRP directs the use of a modifier to indicate "specific required documentation on file." Use of this modifier constitutes a statement to the effect that the supplier actually has the documentation on file that the LMRP requires for the particular item or service. The following LMRPs are affected by this change:

- Epoetin (Erythropoetin)
- External Infusion Pumps
- Home Blood Glucose Monitors
- Negative Pressure Wound Therapy
- Orthopedic Footwear
- Osteogenesis Stimulators
- Pressure Reducing Support Surfaces-Group 1
- Pressure Reducing Support Surfaces-Group 2
- Refractive Lenses
- Respiratory Assist Devices
- Speech Generating Devices
- Therapeutic Shoes for Diabetics
- Urological Supplies
- Walkers

Under the standard grace period, modifier ZX will continue to be accepted on claims with dates of service on or after July 1, 2002, that are received by September 30, 2002. Claim lines with modifier ZX with dates of service on or after July 1, 2002, that are received on or after October 1, 2002, will be rejected or denied as invalid coding.

Medical Policy

New Benefit Category Determinations

The Centers for Medicare & Medicaid Services (CMS) has issued a determination that clitoral therapy devices do not fall within one of Medicare's statutorily defined benefit categories. Also, a similar determination was rendered for wigs. As a result of the benefit category determinations, these items are noncovered.

Home Blood Glucose Monitors and Hypoglycemia

According to the national policy and local medical review policy (LMRP) for home blood glucose monitors (Coverage Issues Manual, Section 60-11 and the Supplier Manual), to be eligible for coverage of a blood glucose monitor (E0607, E2100 or E2101) and diabetic testing supplies, the beneficiary must have diabetes mellitus (ICD-9 codes 250.00-250.93). While hypoglycemia (low blood sugar) can be a complication associated with the treatment of diabetes, hypoglycemia may also be associated with other medical conditions unrelated to diabetes mellitus. Therefore, if the beneficiary's primary diagnosis is hypoglycemia, or they have hypoglycemia due to other medical conditions and do not have diabetes, then ICD-9 codes 251.01-251.9 should be used. Home blood glucose monitors and testing supplies for patients with hypoglycemia as a primary diagnosis or hypoglycemia due to other conditions in the absence of a diabetes diagnosis are noncovered.

Supplier Manual Policy Revisions

In the accompanying Supplier Manual revision, the following local medical review policies (LMRPs) have been revised. A brief summary of the changes in each LMRP is described; however, suppliers are advised to review each LMRP for complete details:

Ankle-Foot/Knee-Ankle-Foot Orthoses *(Effective for dates of service [DOS] on or after April 1, 2002)*
- New HCPCS code descriptors adding "prefabricated"
- New descriptor for HCPCS code L4396
- Deleted splint HCPCS codes now under local carrier jurisdiction - L2102, L2104, L2122, L2124
- Per June 2000 newsletter article, definition of custom-fabricated added
- Added RT and LT modifiers
- Added new GY modifier to be used for non-covered conditions

Commodes *(Effective for DOS on or after July 1, 2002)*
- New HCPCS "E" code replacing "K" code for extra wide, heavy-duty commodes
- New HCPCS code for commode with seat lift mechanism and coverage criteria allowing for its reimbursement
- New KX modifier to be used with a commode with seat lift mechanism, if Coverage and Payment Rules have been fulfilled

Continuous Positive Airway Pressure Devices *(Effective for DOS on or after July 1, 2002)*
- Updated Coverage and Payment Rules to reflect National Coverage Decision to cover CPAP based on Apnea-Hypopnea Index (AHI)
- Eliminated the Certificate of Medical Necessity (CMN)
- New KX modifier to be used to indicate coverage criteria met
- Revised verbiage of HCPCS code K0184
- Allow coverage of either heated or non-heated humidifier with a covered CPAP device

Dialysis Supplies *(Effective for DOS on or after July 1, 2002)*
- All HCPCS codes for "kits" have been eliminated and replaced by new codes for individual supply items
- Addition of KX modifier to be used only when the supplier has a written agreement with the backup dialysis facility and all other Coverage and Payment Rules have been fulfilled
- Re-emphasis on using the EM modifier for emergency supplies only once in the lifetime of a beneficiary

Enteral Nutrition *(Effective for DOS on or after April 1, 2002)*
- HCPCS code B4086 replaced HCPCS codes B4084 and B4085
- ZY modifier deleted; enteral nutrients not administered through feeding tube now coded using HCPCS code A9270
- Expected range of calories/kg/day eliminated

External Infusion Pump *(Effective for DOS on or after July 1, 2002)*
- C-peptide level minimum raised to < 110% of lower limit of normal of laboratory's measurement method for coverage criteria of insulin infusion pump
- HCPCS code K0548 added for insulin lispro
- Expanded allowable dosage range for dopamine (2-5 mcg/kg/min)
- Replaced ZX modifier with KX modifier

Home Blood Glucose Monitors *(Effective for DOS on or after July 1, 2002)*
- New HCPCS codes E0620, E2100, E2101 and A4257

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- Added definition of HCPCS code E0620 (skin piercing device for collection of capillary blood, laser, each)
- Deleted HCPCS code E0609 and crosswalked to HCPCS codes E2100 and E2101
- Coverage and Payment Rules addition for HCPCS code E2101
- Updated ICD-9 code range for diabetes mellitus in Coverage and Payment Rules
- Replaced ZX modifier with KX modifier
- Changed timeframe for new prescription from every 6 months to every 12 months
- Application of Least Costly Alternative authority to E0620 and A4257

Hospital Beds *(Effective for DOS on or after April 1, 2002)*
- Added new HCPCS code E0316
- Deleted requirement to list ICD-9 diagnosis codes for bed cradles (E0280)

Immunosuppressive Drugs *(Effective for DOS on or after April 1, 2002)*
- Added new HCPCS code J7511
- Added HCPCS code J7511 to Coverage and Payment Rules

Lower Limb Prostheses *(Effective for DOS on or after April 1, 2002)*
- Included HCPCS code changes that have been made since the LMRP was last published - L5301-L5341, L5671, L5704-L5707, L5847, L5968, L5975, L5979, L5988-L5990, L8420, L8430, L8470, L8480
- Added statements concerning provision of prostheses to patients prior to discharge from a hospital or skilled nursing facility (SNF), which have been previously published
- Revised section on replacement of prostheses
- Added Coding Guidelines on suspension locking mechanisms
- Clarified documentation needed to support the use of a "K" modifier on a claim, based on functional level of beneficiary (K0-K4)

Nebulizers *(Effective for DOS on or after April 1, 2002)*
- Expansion of coverage for large volume nebulizers with saline or water for use with tracheobronchial stents (ICD-9 code 519.1)
- Expansion of indications for use of pentamidine with added ICD-9 codes
- Expansion of indications for use of pentamidine mucolytics with added ICD-9 codes
- New HCPCS "E" codes replace "K" codes
- New HCPCS codes for inhaled corticosteroids
- Revised HCPCS code for albuterol to include levalbuterol and its proper billing unit

Pneumatic Compression Devices used in Treatment of Lymphedema *(Effective for DOS on or after January 14, 2002)*
Based on a CMS national coverage decision, the distinction between lymphedema and chronic venous insufficiency (CVI) and the respective Coverage and Payment Rules for use of these devices, for either condition, is further clarified (see the "Pneumatic Compression Devices - Clarification" article in this edition of the *DMERC Medicare News*).

Respiratory Assist Devices *(Effective for DOS on or after July 1, 2002)*
- New criteria for Obstructive Sleep Apnea (OSA), involving an Apnea-Hypopnea Index (AHI)
- Liberalization of documentation requirements for the beneficiary and physician compliance statements (see related article in this edition of the *DMERC Medicare News*)
- Liberalization extending coverage and separate payment for heated humidifiers (K0531), when prescribed for use with a covered RAD without backup rate (K0532)
- RAD with backup rate used with invasive interface (K0534) added to explain when to bill this code
- ZX modifier replaced by KX modifier

Spinal Orthoses *(Effective for DOS on or after July 1, 2002)*

- Included HCPCS code changes that have been made since the LMRP was last published - L0315, L0317, L0321, L0331, L0391, L0515, L0561, L0986
- Eliminated HCPCS codes K0112 and K0113
- Added or revised definitions for several terms used in HCPCS code descriptors
- Added statements concerning coverage of orthoses relating to inpatient hospital or SNF stays, which have been previously published in bulletins
- Added noncoverage statement of HCPCS code L0984, which was previously published

Suction Pumps *(Effective for DOS on or after April 1, 2002)*

- New HCPCS code for gastrointestinal suction pumps, as distinguished from tracheal suction pumps
- New HCPCS "A" codes replacing "K" codes for canisters and tubing
- Definitional distinction between tracheal and oral suction catheters
- Allowance of an additional ICD-9 diagnosis code for coverage of tracheal suction equipment and supplies

Surgical Dressings *(Effective for DOS on or after April 1, 2002)*

- Included HCPCS code changes that have been made since the LMRP was last published - A6010-A6024, A6196-A6202, A6222-A6224, A6231-A6233
- Current HCPCS code for tape, A6265, made invalid for DMERC and two new HCPCS codes for tape, K0572 and K0573, established
- Substituted GY modifier for ZY modifier
- Added coverage and coding guidelines for compression bandage systems, used for the treatment of venous stasis ulcers
- Added statement about coverage of compression dressings
- Revised coverage statements concerning secondary dressings to allow for multi-layer, compression bandage systems
- Revised statements regarding kits to clarify coverage of medically necessary components of kits
- Removed specific mention of nurse practitioners, physician assistants, and other non-physician practitioners in statements about documentation requirements. This is to be consistent with wording in other LMRPs. The general statements about the acceptance of orders from non-physician practitioners, which are found in the Supplier Manual, continue to apply.
- Impregnated, roll gauze dressings, designed for the treatment of venous stasis ulcers (e.g., unna boot), are coded using HCPCS code A6266

Therapeutic Shoes for Diabetics *(Effective for DOS on or after July 1, 2002)*

- Crosswalked HCPCS code A5502 to A5509, A5510 and A5511
- Non-coverage statement for HCPCS code A5510
- Updated ICD-9 code range for diabetes mellitus in Coverage and Payment Rules
- Added RT and LT modifiers
- Replaced ZX modifier with KX modifier
- Clarified that HCPCS code A5507 can be used for repairs to diabetic shoes
- Clarified that the certifying physician may not be a podiatrist

Urological Supplies *(Effective for DOS on or after July 1, 2002)*

- Added HCPCS codes A4319, A4324, A4325, A4331-A4333, A4348, A4360, K0572 and K0573
- Deleted HCPCS codes A4329, A4359, A4554, A5149, A6265, K0280, K0281, K0407-K0409 and K0411
- Added new GY modifier to be used for non-covered conditions
- Replaced ZX modifier with KX modifier

Rib Belts and Abdominal Binders Now Covered

The Centers for Medicare & Medicaid Services (CMS) has issued a determination that elastic rib belts (A4572, L0210, L0220) and abdominal binders (A4462) may be covered as braces when they are used in the following fashion:

- The brace serves a medical purpose and it is only associated with treating an illness, injury, or malformed body member;
- It provides support and counter force (a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace;
- It is not a device used to supply compression therapy (for example, to reduce the size, volume, or swelling of a body member or to help circulation);
- It is not a device used for convenience or appearance;
- It is not a device used for cosmetic purposes.

Coverage applies to claims for dates of service on or after August 1, 2001.

Policy Revision - CPAP

The accompanying Supplier Manual revision contains the Continuous Positive Airway Pressure (CPAP) device local medical review policy (LMRP). The revised LMRP updates the Coverage and Payment Rules to reflect the National Coverage Decision (NCD) allowing use of an Apnea-Hypopnea Index (AHI) for the diagnosis of obstructive sleep apnea. In addition, the revised LMRP provides instructions for continued coverage of the device beyond the first three months, clarifies that accessories used with a CPAP device are separately reimbursable, and provides coverage reimbursement for heated humidifiers used with a CPAP device.

A major change within the revised LMRP is the elimination of the CPAP Certificate of Medical Necessity (CMN). In lieu of a CMN, the supplier must use a KX modifier to indicate that the Coverage and Payment Rules have been met. KX modifier use applies to both the E0601 and accessories. Suppliers should note that the LMRP is effective for dates of service on or after July 1, 2002. However, the change in the national policy (Coverage Issues Manual, Section 60-17) to cover CPAP based on the AHI is effective for dates of service on or after April 1, 2002. Therefore, the following instructions must be followed by suppliers submitting claims for code E0601 and related accessories:

<u>Dates of Service prior to April 1, 2002:</u>
HCFA-1500 form and CPAP CMN - LMRP and CIM Section 60-17 in effect for these dates of service

<u>Dates of Service on or after April 1, 2002, but prior to July 1, 2002:</u>
HCFA-1500 form with E0601 and accessories - No modifier; No CMN; No LMRP; Revised CIM Section 60-17 in effect

<u>Dates of Service on or after July 1, 2002</u>
HCFA-1500 form with E0601 and accessories - No CMN; KX modifier on E0601 and accessories if revised LMRP requirements are met; Revised CIM Section 60-17 in effect

There is no LMRP in effect for dates of service between April 2002 and July 2002; however, claims for CPAP devices and accessories are still bound by the requirements in the revised national policy CIM, Section 60-17. National policy requires that initial claims for CPAP devices must be supported by documentation in the medical record indicating that the patient meets Medicare's stated coverage criteria. This information must be available to the DMERC upon request.

RAD Policy: Update on Timing of Beneficiary/Physician Statement Completion

The Respiratory Assist Device (RAD) local medical review policy (LMRP) has certain timing requirements that has been revised in the accompanying Supplier Manual revision.

What has not changed and remains a requirement:

- The beneficiary and physician may not complete or sign their respective statements attesting to the beneficiary's compliant use of the device any time prior to the 61st day after date of issue.

What has changed:

- The beneficiary no longer has to see the physician within the same month that the Beneficiary Statement is completed.
- An office visit is not required for statement completion if the physician is able to otherwise ascertain the facts needed to do so, and those facts are accurately reflected in the progress notes of the patient's medical chart.
- Neither the beneficiary nor the physician needs to complete and sign the statement by the 90th day. However, the supplier may not submit a claim(s) for the fourth or succeeding months' services using the ZX modifier (KX on or after July 1, 2002), until or unless both statements have been completed, signed, and indicate that all other LMRP coverage criteria referenced in the statements (see the RAD LMRP in the Supplier Manual) have been fulfilled.
- Only after both statements have been returned as described, even if either one is signed after the 90th day, the supplier may submit claims with a ZX (KX) modifier for those months (on or after the 61st day) during which the statements were lacking. (If a beneficiary and physician are attesting to continued compliant use and benefit even later than the 90th day, it only serves as stronger evidence of the beneficiary's commitment to continued use of the equipment and justification for Medicare's continued reimbursement for it.)

As an example, if use of a RAD is begun on July 1, a qualifying physician statement is not obtained until October 15, a qualifying beneficiary statement is not obtained until November 20, and the claims for October 1 and November 1 (e.g., the fourth and fifth months' claims) are not submitted until on or after November 20 (i.e., after both statements have been obtained), the ZX (KX) modifier may be added to the appropriate claim lines. However, if the October 1 and November 1 claims are submitted before November 20, the ZX (KX) modifier may not be added.

Pneumatic Compression Devices - Clarification

Pneumatic compression devices consist of an inflatable garment for the arm or leg and an electrical pneumatic pump that fills the garment with compressed air. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices. Pneumatic devices are covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers.

Lymphedema: Lymphedema is the swelling of subcutaneous tissues due to the accumulation of excessive lymph fluid. The accumulation of lymph fluid results from impairment to the normal clearing function of the lymphatic system and/or from an excessive production of lymph. Lymphedema is divided into two broad classes according to etiology. Primary lymphedema is a relatively uncommon, chronic condition which may be due to such causes as Milroy's Disease or congenital anomalies. Secondary lymphedema, which is much more common, results from the destruction of or damage to formerly functioning lymphatic channels, such as surgical removal of lymph nodes or post radiation fibrosis, among other causes.

Pneumatic compression devices are covered in the home setting for the treatment of lymphedema if the patient has undergone a four-week trial of conservative therapy and the treating physician determines that there has been no significant improvement or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression.

Chronic Venous Insufficiency With Venous Stasis Ulcers

Chronic venous insufficiency (CVI) of the lower

extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in the veins. Signs of CVI include hyperpigmentation, stasis dermatitis, chronic edema, and venous ulcers.

Pneumatic compression devices are covered in the home setting for the treatment of CVI of the lower extremities only if the patient has one or more venous stasis ulcer(s) which have failed to heal after a 6 month trial of conservative therapy directed by the treating physician. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb.

General Coverage Criteria: Pneumatic compression devices are covered only when prescribed by a physician and when they are used with appropriate physician oversight, i.e., physician evaluation of the patient's condition to determine medical necessity of the device, assuring suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.

The determination by the physician of the medical necessity of a pneumatic compression device must include (1) the patient's diagnosis and prognosis; (2) symptoms and objective findings, including measurements which establish the severity of the condition; (3) the reason the device is required, including the treatments which have been tried and failed; and (4) the clinical response to an initial treatment with the device. The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the patient (or caregiver) to apply the device for continued use in the home.

The only time that a segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a nonsegmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber.
Please refer to the Pneumatic Compression Devices (used for Lymphedema) local medical review policy in the accompanying supplier manual revision.

Miscellaneous

Return/Reject Denials

Claims denied with a return/reject action code should be resubmitted as a new claim. In this case, please do **not** attach a Remittance Advice (RA) or Medicare Summary Notice (MSN) to the new claim. You will need to correct or add the information needed and submit as you would a new claim to:

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

All claims with the return/reject denials sent for reconsideration of the denial will be dismissed as they have no appeal rights.

Change of Address

Suppliers that have moved or had an address change must inform the National Supplier Clearinghouse (NSC) of their new address(es). The NSC needs the new address(es) and telephone number to update the supplier files and ensure that Medicare payments and mailings are sent to the correct address(es).

With the new "Do Not Forward" initiative, the DMERCs have been instructed to mail all checks and remittance advices in envelopes with a "Do Not Forward" request. If a check or Remittance Advice is returned due to incorrect address, the DMERCs inform the NSC of the problem. The DMERCs will then hold all payments (including electronic funds transfer) until the NSC notifies the DMERC that the supplier has updated their new information with the NSC.

Please contact the NSC toll-free at telephone number 866-238-9652 for information on how to update your address.

CIGNA Medicare Selected for Wheelchair Demonstration Project

The Centers for Medicare & Medicaid Services (CMS) has selected CIGNA Healthcare - Medicare Administration as the contractor to process claims for the Consumer Directed Durable Medical Equipment (CD-DME) Wheelchair Demonstration project. CMS anticipates that the project will begin sometime in Spring 2002 and run for approximately three years.

CMS and CIGNA Medicare will partner with four Centers for Independent Living (CILs), whose staff will educate beneficiaries to be savvy purchasers of wheelchairs (either manual or power). The CILs are located in Tulsa, OK, Portland, ME, Pittsburgh, PA, and Worcester, MA. A beneficiary, with the assistance of CIL staff members, will collect and submit medical records, product information about the wheelchair and accessories selected and other documentation to CIGNA Medicare to determine if they qualify for a wheelchair. If approved, the beneficiary will receive a "voucher" indicating a dollar amount that they may spend to purchase a wheelchair and accessories. In addition, the claim will be assigned an approval number that the beneficiary will furnish to the DMEPOS supplier submitting the wheelchair claim. The beneficiary then selects a wheelchair supplier and "negotiates" a best price. Suppliers should note that beneficiaries will be purchasing the wheelchair and accessories selected, even though the model chosen may normally be a capped rental item.

DMEPOS suppliers selected by a beneficiary participating in the CD-DME project must submit the wheelchair claim, model and accessory information, and Certificate of Medical Necessity (CMN) in hard copy. An approval number, given to the beneficiary at the time CIGNA Medicare authorizes their claim, should be listed in Block 19 of the HCFA-1500 form. In addition, claims submitted for beneficiaries participating in the CD-DME project must be sent to CIGNA Medicare, not your local DMERC. The address for claim submission is:

CIGNA Healthcare - Medicare Administration
Attn: CD-DME Project
P.O. Box 22059
Nashville, TN 37202

This information may also be accessed on the CIGNA Medicare Web site at *www.cignamedicare.com/dmerc*.

SNF CB Coding Information on CMS Web Site

As of January 1, 2002, coding information for Skilled Nursing Facility (SNF) Consolidated Billing (CB) may be found on the Centers for Medicare & Medicaid Services (CMS) Web site at *www.hcfa.gov/medlearn/refsnf.htm* under the topic "Consolidated Billing for Skilled Nursing Facility Residents Claims Billed to Medicare Carriers or DMERCs by Physicians, Non-Physician Practitioners, and Suppliers." This information may be used by suppliers to determine by procedure code whether services rendered to beneficiaries in Part A covered SNF stays or non-Part A covered SNF stays (Part A benefits exhausted) are included or excluded from CB. Services that are included in CB must be billed to the SNF for payment. These files are for services rendered in calendar year 2002. Suppliers will be notified of any subsequent coding changes.

Four code files will be found on the Web site:

- Codes for physician professional services (other than the interpretation of diagnostic tests) that, when rendered to beneficiaries in a Part A covered stay, are not included in CB and must be submitted to the carrier or DMERC for payment.
- Codes for the physician interpretation of diagnostic tests that, when rendered to beneficiaries in a Part A covered stay and submitted with a 26 - professional component modifier, are not included in CB. These services must be submitted to the carrier for payment.
- Codes for ambulance services that will always be included in CB when submitted with an NN modifier and must not be submitted to the carrier for payment. These services must be submitted to the SNF for payment. There are additional situations in which ambulance services are consolidated. Refer to Program Memorandum AB-01-159 to identify these situations.
- Codes for physical, occupational, and speech therapy services that, when rendered to a beneficiary in a non-Part A covered stay (i.e., Part A benefits exhausted), are included in CB and may not be submitted to the carrier for payment. They must be submitted to the SNF for payment.

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.

The Medicare Appeals Process

Under DMERC Medicare, when a claimant is dissatisfied with an initial determination on the amount Medicare pays on a claim or whether services received are covered by Medicare, they have the right to appeal the decision. The appeals process consists of five levels. Each level, after the initial determination, has procedural steps that must be taken by the appellant before an appeal may be taken to the next level (see table below).

Appeal Level	**Time Limit For Filing Request**	**Monetary Threshold To BeMet**
Review	6 months from date of initial determination	None
Hearing Officer (HO)Hearing	6 months from date of review determination	At least $100 remains in controversy
Administrative Law Judge (ALJ) Hearing	Filed within 60 days of receipt of HO hearing decision	At least $500 remains in controversy (at least $100 for home health services)
Departmental Appeals Board DAB) Review	Filed within 60 days of receipt of ALJ hearing decision/dismissal	None
Federal Court Review	Filed within 60 days of receipt of DAB decision or declination of review by DAB	At least $1,000 remains in controversy

A party dissatisfied with the review determination, where at least $100 remains in controversy, may request a Hearing Officer (HO) hearing. The HO Hearing is the second level of appeal, performed after a review determination has been issued. If a review request is dismissed for any reason, the appeals process is considered complete, and the HO hearing cannot be requested. If a review request is dismissed due to untimely filing, good cause may be established. Examples of good cause may be found where a fire destroys records or a flood closes an office for an extended period of time, or other such natural catastrophes (see Medicare Carriers Manual Section 12008.6, Examples of Situations Where Good Cause for Late Filing Exists for Physicians or Other Suppliers). When a case for good cause has been established for the request being untimely, the appeals process remains at the review level and not at the HO hearing.

There are three kinds of HO Hearings that an appellant may request: In-person, Telephone, and On-the-Record. The purpose of the hearing is to arrive at the correct decision about the issue(s) in dispute. Therefore, the appellant is given the opportunity to request the type of hearing that is best for him/her.

If the appellant meets the procedural steps at a specific level, the appellant is then afforded the right to appeal any determination/decision to the next level in the process. The amount in controversy is defined as the dollar amount at issue that must remain to establish the right to a particular level of appeal. The amount in controversy requirements are established by Congress.

Calculating the Amount in Controversy: The amount in controversy is computed as the actual amount charged the beneficiary for the item(s) and/or service(s) being appealed, less any allowed amount and less any deductible and coinsurance amounts applicable to the particular claim or claims involved. The decision about whether the amount in controversy requirement has been met is made by the HO at the HO level, and by the ALJ at the ALJ level.

General Calculation:
Step 1:
Total amount charged for items/services in dispute - Total amount allowed for items/services in dispute = Difference

Step 2:
Difference (from Step 1) - Unmet deductible = Balance

NOTES: The Balance in Step 2 is the amount that remains in controversy if the services are not subject to coinsurance.

For services subject to coinsurance, proceed to Step 3. Unmet deductible refers to any unmet Part B blood deductible, if applicable, as well as the routine Part B cash deductible.

Step 3:
Balance (from Step 2) X 0.80 = Amount that remains in controversy, for services subject to coinsurance.

Calculating the Amount in Controversy for Overpayments: The amount in controversy for an overpayment is the actual amount of the overpayment contained in the demand letter. This amount is not subject to reduction due to coinsurance and deductibles that have already been paid.

Exclusions: Calculation of the amount in controversy may take into account only those claims and items/services that are part of the review decision. The HO may not consider claims included in a later appeal request, except in cases of aggregation of claims, discussed below.

Aggregation of Claims to Meet the Amount in Controversy: Under the aggregation rules, claims may be combined to meet the amount in controversy requirements. The calculation is the same as that discussed above. The decision about whether the amount in controversy requirement has been met is made by the HO at the HO level, and by the ALJ at the ALJ level.

Announcement - New Automated Response Unit Coming Soon

HealthNow is pleased to announce that a new, more functional Automated Response Unit (ARU) will soon be implemented for the DMERC A. The new ARU will allow suppliers to spend up to an hour obtaining claim status information without having to re-enter the supplier number each time. Also, general policy information will be available without ever having to enter your supplier number or a Medicare number.

The ARU will be available 24 hours a day, every day of the week. However, claims status inquiry availability will be dependent on the host system being available. If the host system is not available, you will receive a message to that effect, and the general policy information will still be available.

The new ARU should be fully functional by approximately mid-March. However, testing will begin soon. During the expected testing dates of March 4, 2002 through March 29, 2002, testing may require that the ARU be unavailable to suppliers during the hours of 7:00 AM to 9:00 AM EST. We are sorry for any inconvenience this may cause you, but hope that you agree the end product with the additional features and functionality was worth the minimal inconvenience to provide much better service to you in the future.

The following is an ARU User Guide for Suppliers. Please note that these instructions may be revised as a result of the testing that will be conducted in March. Any revisions will be published on our Web site at *www.umd.nycpic.com.*

The Medicare ARU

The Medicare ARU is DMERC A's automated information system. Using a touch-tone telephone, you can:

- Listen to information about new legislation or supplier issues.
- Listen to general information regarding Durable Medical Equipment.
- Listen to information regarding the Appeals Process.
- Listen to information regarding the Program Safeguard Contract.
- Request a duplicate Remittance Advice.
- Obtain information regarding the status of a claim. This includes the processing status of the claim, deductible information applicable to the claim, payment information applicable to the claim, including payment amount, payment date and check number or information on claim denial.
- Obtain information on the amount submitted for the total claim and a breakdown of individual line items.

- Obtain information on the amount approved for the full claim and a breakdown of individual lines.
- Speak with the EDI Helpdesk.

If you have difficulty using the ARU, we have included some instructions to make it easy.

Instructions

The ARU is easy to use. All you need to receive quick information is a touch-tone telephone and the following information:
- Your National Supplier Clearinghouse number (the ten-digit supplier number)
- The beneficiaries' Medicare number, either starting with or followed by a letter
- The date of service in question

Step One:

Call 866-419-9458, daily, 24 hours a day. Functions requiring host interaction (e.g., claim status) will be unavailable only when the host is down for maintenance. **Reminder:** Customer Service Representatives are only available Monday through Friday between the hours of 7:30 AM and 4:30 PM EST.

Step Two:
- To listen to new legislation, supplier notices, supplier alerts, or other supplier issues, **PRESS 1**.
- To listen to information on a specific claim or to receive a copy of a duplicate Medicare Remittance Advice, **PRESS 2**. If option two is selected, then follow steps three through seven.
- To speak with the EDI Helpdesk, **PRESS 3**. (Reminder: EDI Representatives are only available Monday through Friday between the hours of 8:30 AM - 12:00 PM and 1:00 PM - 4:00 PM EST.)
- To listen to general information regarding durable medical equipment, **PRESS 4**. (This includes information on equipment repair, Advance Determination of Medicare Coverage, releasable information and the DMERC A Web site.)
- To listen to information on the Program Safeguard Contract, **PRESS 5**.
- To listen to information on the appeals process, **PRESS 6**.
- To repeat these choices, **PRESS 9**.
- To speak with a Customer Service Representative, **PRESS 0**.
- To end the call at any time, **PRESS ***.

Step Three:
- Enter the ten-digit NSC number and **PRESS #**. The system will repeat the NSC number you entered and ask you to confirm it.
  - If the number is correct, **PRESS 1**.
  - If the number is not correct, **PRESS 2** to re-enter your NSC number.

Step Four:
- If the beneficiary has a Part B Medicare number (the Medicare number ends with a letter), **PRESS 1**.
- If the beneficiary has a Railroad beneficiary number (the Medicare number starts with a letter or letters), **PRESS 2**.

Step Five:

If the beneficiary has a Part B Medicare number and you pressed one, then enter the nine digit Medicare number, then when prompted, indicate the letter at the end of the Medicare number as follows:

If the letter is:	**PRESS**:
A	1
B	2
C	3
D	4
T	5
M	6

- If there is a number following the letter, press that number when prompted.
- If there is no number after the letter, **PRESS #**.
- Any other suffix **PRESS 0** for a Customer Service Representative.

If the beneficiary has a Railroad Medicare number and you pressed two, then the letter at the beginning of the Medicare number must be indicated first. Do the following to indicate the letter at the beginning of the Medicare number:

If the letter is:	**PRESS:**
A	1
MA	2
WA	3
WCA	4
CD	5

After indicating the letter at the beginning if the Medicare number, enter the nine-digit Medicare number when prompted. If the prefix is any letter other than the ones listed, **PRESS 0** for a Customer Service Representative.

Step Six:
- To receive information about a claim, **PRESS 1**.
  If option one is selected, follow steps seven through eight.
- To receive a duplicate Remittance Advice, **PRESS 2**.
  If option two is selected, then follow step nine.

Step Seven:
- Enter the two-digit month of service.
- Enter the two-digit day of service.
- Enter the four-digit year of service.
- For additional information and a line-by-line breakdown, **PRESS 3**.

Step Eight:
- To request information on another claim, **PRESS 1**.
- To return to the claims menu, **PRESS 2**.
- To return to the main menu, **PRESS 9**.
- To speak with a Customer Service Representative, **PRESS 0**.
- To end this call at any time, **PRESS ***.

Step Nine:
- Enter the beneficiary's two-digit month of birth.
- Enter the beneficiary's two-digit day of birth.
- Enter the beneficiary's four-digit year of birth.
- Enter the claim control number and **PRESS #**.
- To request another duplicate Remittance Advice for the same claim control number, **PRESS 1**.

Fees for Dialysis Supplies and Equipment

As previously published in the December 2001 edition of the *DMERC Medicare News*, suppliers are required to bill for dialysis supplies using existing and newly created HCPCS codes for individual dialysis supplies, for dates of service on or after January 1, 2002. The following are the fees for the published dialysis and equipment HCPCS codes:

ESRD Fees (Effective January 1, 2002)

Code	Fee	Code	Fee	Code	Fee
A4651	*IC	A4737	*IC	E1530	*IC
A4652	*IC	A4740	*IC	E1540	*IC
A4656	0.85	A4750	7.35	E1550	*IC
A4657	0.48	A4755	9.37	E1560	*IC
A4660	*IC	A4760	*IC	E1570	100.49
A4663	56.28	A4765	4.49	E1575	26.87
A4680	110.25	A4766	*IC	E1580	*IC
A4690	103.92	A4770	22.06	E1590	1721.69
A4706	11.99	A4771	71.70	E1592	*IC
A4707	4.27	A4772	57.44	E1594	1051.78
A4708	*IC	A4773	26.68	E1600	461.86
A4709	9.23	A4774	*IC	E1610	614.64
A4712	1.19	A4801	0.42	E1615	*IC
A4714	*IC	A4802	5.64	E1620	*IC
A4719	7.12	A4860	30.61	E1625	*IC
A4720	14.73	A4870	*IC	E1630	*IC
A4721	20.38	A4911	12.53	E1632	*IC
A4722	18.79	A4918	*IC	E1635	*IC
A4723	28.19	A4927	6.65	E1636	*IC
A4724	28.45	A4928	7.64	E1637	3.99
A4725	27.90	A4929	0.20	E1638	36.12
A4726	33.48	E1500	*IC	E1638RR	3.61
A4730	1.37	E1510	1984.50	E1639	223.34
A4736	*IC	E1520	*IC	E1639RR	22.33

**IC is individual consideration*

To see the complete 2002 Fee Schedule, and subsequent updates, visit our Web site at *www.umd.nypic.com*. To receive a hardcopy version of specific fees, please submit your request in writing to:

HealthNow New York Inc.
Attn: FOI
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

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.

Timely Filing Reminder

Supplier Notice 2001-31
December 13, 2001

This is a reminder that the **deadline** for filing claims with dates of service **October 1, 1999 through September 30, 2000** is as follows:

All **paper** claims filing must be postmarked no later than December 31, 2001.

All **electronic** claims filing must be received on our Bulletin Board System by 6:00 PM, December 31, 2001, and pass through our front-end edits.

Correction to DMEPOS Fee Schedules

Supplier Notice 2001-32
December 21, 2001

The Centers for Medicare & Medicaid Services (CMS) determined that the DMEPOS fee schedule payment methodology applies to DMEPOS items and not to repair of DMEPOS items. Therefore, the fee schedules established for repair codes E1340, L4205, L7520, and L8049 are being discontinued effective January 1, 2002.

Effective for services furnished on or after January 1, 2002, we will revert back to the payment method in use prior to the establishment of the fee schedules for these codes.

Please refer to the 2001 Fee Schedule for allowances.

Attention: All Electronic Submitters

Supplier Notice 2002-01
January 4, 2002

This is a reminder that the Bulletin Board System is moving to our home office in Binghamton, NY the weekend of January 19, 20 and 21, 2002.

Our Bulletin Board System will be unavailable to accept claims submissions or retrieve electronic remittance notices from 6:00 PM Friday, January 18, 2002 through 8:00 AM Tuesday, January 22, 2002.

The phone numbers for the Bulletin Board Systems have also changed as of January 22, 2002. The new numbers are:

Claims submission: **607-766-6349**

Electronic remittance retrieval: **607-766-6409**

Please change these phone numbers in your communications software as of January 22, 2002.

2002 Fee Schedule Available on Our Web Site Thursday, January 10, 2002

Supplier Notice 2002-02
January 9, 2002

The 2002 Fee Schedule will be available on our Web site on Thursday, January 10, 2002. You can access the 2002 Fee Schedule by following these steps:

Access our Web site at *www.umd.nycpic.com*.
Click on the **DMERC** side.
Click on the **Fee Schedules** option under **Suppliers**.

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.

Attention ProComm Connections 4.6 Users

Supplier Notice 2002-03
January 10, 2002

As we informed you in Supplier Notice 2001-28 (Bulletin Board Equipment Move), the DMERC A will be moving the Bulletin Board Systems telecommunications equipment to its home office in Binghamton, NY. Because of this move, you must change to the new dial-in telephone numbers for both claims submissions and retrieval of electronic remittance notices through the Bulletin Board Systems.

To Change the Dial-in Number for the DMERC A Claims Submission Bulletin Board System (as of January 22, 2002):

- Click on **Start**.
- Go to **Programs**.
- Go to **Procomm Plus**.
- Go to **Procomm Plus** again. Clicking this will launch ProComm. Once it has opened you will see Procomm Plus Ready.
- Click **File**, and then click on **Connection Directory**.
- Select the Medicare Entry from the list.
- Change the Area Code to: 607.
- Change the Data Number to: 766-6349.
- Click **OK**. You may now proceed as normal.

To Change the Dial-in Number for the DMERC A Remittance Bulletin Board System (as of January 22, 2002):

- Click on **Start**.
- Go to **Programs**.
- Go to **Procomm Plus**.
- Go to **Procomm Plus** again. Clicking this will launch Procomm. Once it has opened, you will see Procomm Plus Ready.
- Click **File**, then click on **Connection Directory**.
- Select the ERN Entry from the list.
- Change the Area Code to: 607.
- Change the Data Number to: 766-6409.
- Click **OK**. You may now proceed as normal.

1st Quarter Update: Drug Fees

Supplier Notice 2002-04
January 18, 2002

The Updated Drug Fees for the 1st quarter of 2002 are now available on the DMERC A Web site.

To access this information on our Web site:

- Visit *www.umd.nycpic.com*.
- Click on the DMERC A logo.
- Under **Suppliers**, click on **Fee Schedules**.
- On the Fee Schedules page, click on **1st Quarter Update: Drug Fees**.

Revision to Supplier Notice 2001-30 ANSI X12N 837 Professional Health Care Claim Companion Document

Supplier Notice 2002-05
January 18, 2002

This notice serves as a revision to the previously issued Supplier Notice 2001-30, "ANSI X12N 837 Professional Health Care Claim Companion Document," dated November 21, 2001. All information as published in Supplier Notice 2001-30 remains applicable. The information in bold type was inadvertently omitted in the original notice.

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837 implementation guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the ViPS Medicare System, VMS, of HealthNow New York Inc. Region A DMERC, Contractor number, 00811. The information in this document is subject to change. Changes will be communicated in the standard "DMERC Medicare News" quarterly news bulletin and on HealthNow New York Inc.'s Web site: www.umd.nycpic.com. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Language

- Negative values submitted in the following fields will not be processed and will result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).

- The only valid values for CLM05-3 (Claim Frequency Type Code) are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and will result in duplicate claim rejection. The claims processing system does not process electronic replacements.

- The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected.

- Claims that contain percentage amounts submitted with values in excess of 99.99 will be rejected.

- Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal will be rejected.

- Data submitted in CLM20 (Delay Reason Code) will not be used for processing.

- HealthNow New York Inc. Region A DMERC will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of

benefits will be submitted in upper case.

- You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the carrier translator.

- The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.

- Currency code (CUR02) must equal 'USA'.

- **Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.**

- Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).

- Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).

- Service unit counts (units or minutes) cannot exceed 999.9 (SV104).

- For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.

- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Non-implementation guide data may not be sent for processing consideration.

- Any data submitted in the PWK (Paperwork) segment may not be considered for processing.

- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).

- HealthNow New York Inc. Region A DMERC will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional or Professional Implementation Guides. Invalid header and trailer segments (ISA, GS, ST, SE, GE and/or IEA) could result in an unexpected outcome during translation.

- HealthNow New York Inc. Region A DMERC may reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.

- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) that is not submitted with a valid carrier code. Each individual Contractor determines this code.

- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) submitted with more than 9,999 loops.

- HealthNow New York Inc. will reject an interchange (transmission) submitted with more than 9,999 segments per loop.

- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.

- You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes will not be considered in

processing.

- Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing will cause the claim or the transaction to be rejected.
- You may send up to four modifiers; however, the last modifier may not be considered.
- HealthNow New York Inc. Region A DMERC will return the first 6-digits of the inbound version as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.
- We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.
- Compression of files using the .zip format is supported for transmissions between the submitter and HealthNow New York Inc. Region A DMERC.

2002 Cap Fees for Therapeutic Shoes

Supplier Notice 2002-06
January 22, 2002

Listed below is the listing of 2002 Special Limitations for Therapeutic Shoes under the Standard Reasonable Charge Rules. These limits apply to codes **A5500 – A5506 and A5509 – A5511**. Reasonable charge fees are established for each state. However, the maximum allowable amount for each code cannot exceed the cap amount. The current cap breakdown for 2002, which is the same for all states, is as follows:

Code	Cap
A5500	$66.00
A5501	$197.00
A5502	$33.00
A5503	$33.00
A5504	$33.00
A5505	$33.00
A5506	$33.00
A5509	$33.00
A5510	$33.00
A5511	$33.00

Telephone Adjustment Requests

Supplier Notice 2002-08
February 25, 2002

Effective March 1, 2002, the Region A DMERC will no longer accept any telephone requests to adjust a claim via the Caller Information Network or the Program Education and Training Telephone Lines. We are discontinuing this practice to prepare for the introduction of our Telephone Review services in the future.

Any adjustment requests received prior to March 1, 2002 will continue to be processed.

If you do not agree with a claim determination, you can file a written review request to:

HealthNow DMERC A
Attn: Program Inquiries Department
P.O. Box 6300
Wilkes-Barre, PA 18773-6300

Revised Timelines for Health Insurance Portability and Accountability Act (HIPAA) Requirements

Supplier Notice 2002-07
February 22, 2002

As per Change Request 2039 issued by the Centers for Medicare & Medicaid Services (CMS) on February 8, 2002, the following dates are now effective for implementation of the HIPAA transaction sets noted below. Any entity, referred to as a "trading partner" below (including COB trading partners and electronic submitters), that submits electronic claims to a Medicare Carrier, must be compliant with these HIPAA transaction standards by October 16, 2002. If a trading partner is not prepared to submit compliant transactions by this date, the trading partner must apply to the Department of Health and Human Services (HHS) for an extension of HIPAA compliance dates. This request must include the trading partner's plan to achieve compliance on or before October 16, 2003. Refer to H.R. 3323, Section 3 for additional information.

Schedule for HIPAA Mandated ANSI Transaction Sets

Transaction Set	Testing to Begin	Testing Completion Date
X12N 837 In-bound Claims	April 16, 2002	October 16, 2002 *
X12N 835 Elec. Remit. Not.	May 16, 2002	October 16, 2002 *
X12N 837 COB Claims	June 17, 2002	October 16, 2002 *
X12N 276/277 Claims Status	July 1, 2002 (testing provided by request only)	
X12N 270/271 Eligibility	Instruction pending	

* OR BEFORE OCTOBER 16, 2003 IF AN EXTENSION IS REQUESTED.

Medicare Free Billing Software

Medicare free billing software for HIPAA compliant ANSI transactions is scheduled to be available for distribution to providers/billers by December 3, 2002. CMS intends to eliminate free software effective fiscal year 2004 (October 2003 through September 2004).

Users of Medicare free billing software (including Accelerate) must request an extension from the Department of Health Human Services in order to continue to use this software between October 16, 2002 and December 3, 2002.

HIPAA Changes

Don't get left behind; get all the up-to-date information on the changing Health Insurance Portability and Accountability Act (HIPAA) information on the DMERC A Web site, *www.umd.nycpic.com*. Click on "DMERC A", click on "EDI", and then click on the new "EDI & HIPAA" link.

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.