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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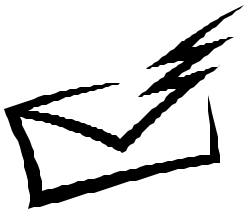

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Table of Contents

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Check Control/MSP Fax	570-735-9594	Program Inquiries Fax (Hearings & Reconsiderations)	570-735-9599
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Billing

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.

Billing for Implanted Durable Medical Equipment (DME), Prosthetic Devices, Replacement Parts, Accessories and Supplies

This is a clarification of a Medicare operational policy on the proper billing for implanted DME, implanted prosthetic devices, replacement parts, accessories and supplies. Claims for implanted DME, implanted prosthetic devices, replacement parts (external or internal), accessories and supplies for the implanted DME must be billed to the local carriers, who will adjudicate claims for these items. The Durable Medical Equipment Regional Carriers (DMERCs) will deny claims submitted for these items under current operating procedures.

[Reference: Change Request (CR) 2227; Transmittal B-02-041]

Payment Limit for Drugs and Biologicals

Drugs and biologicals not paid on a cost or prospective payment basis are paid based on the lower of the billed charge or 95% of the average wholesale price (AWP) as reflected in sources such as the Red Book, Price Alert, or Medispan. Examples of drugs that are paid on this basis include, but are not limited to drugs, furnished incident to a physician's service, immunosuppressive drugs furnished by pharmacies, drugs furnished by pharmacies under the durable medical equipment benefit, covered oral anti-cancer drugs, and drugs furnished by independent dialysis facilities that are not included in the end stage renal disease composite rate payment. This policy continues unchanged from the policy described in Change Request 745, Transmittal AB-00-110, dated April 3, 2000.

[Reference: Change Request (CR) 2123; Transmittal AB-02-075]

CPAP Documentation and KX Modifier Usage

Recently, the local medical review policy (LMRP) on Continuous Positive Airway Pressure (CPAP) Devices (DMERC A #14.11) was published and included documentation requirements for the use of the **KX** modifier. Questions have arisen regarding the use of the **KX** modifier for beneficiaries with CPAP therapy initiated prior to the July 1, 2002, effective date of the policy.

The policy stipulates that in order to use the **KX** modifier for the fourth month's claim, and for any month thereafter, evidence of continued use of the device must be obtained from either the beneficiary or the treating physician. Therefore, regardless of the start date of CPAP therapy, in order to bill Medicare and use the **KX** modifier, suppliers must ascertain that the beneficiary is continuing to use the CPAP device. This requirement is not new or unique to the CPAP policy, but rather applies to all capped rental payment category items. This information does not have to be submitted with the claim, but must be retained in the supplier's files and be available to the DMERC upon request.

Item 32 of the HCFA-1500 Form

Effective October 1, 2002, the Medicare Carriers Manual (MCM) is revised to no longer allow "SAME" to be entered in Item 32 of the HCFA-1500 form, when the address is the same as in Item 33. Per Part 3, Section 4020.2 and Part 4, Section 2010.2, enter the name, address, and zip code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.

Providers of service (namely physicians) must identify the supplier's name, address, zip code and Personal Identification Number (PIN) when billing for purchased diagnostic tests. When more than one supplier is used, a separate HCFA-1500 should be used to bill for each supplier. This item is completed whether the supplier personnel performs the work at the physician's office or at another location.

[Reference: Change Request (CR) 1658; Transmittals 1751 and 26]

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DMERC Coverage and Billing of Treprostinil (Remodulin®)

In May 2002, the Food and Drug Administration (FDA) approved treprostinil for the treatment of pulmonary artery hypertension. Treprostinil is administered via subcutaneous injection using a type of infusion pump, similar to the pump used for subcutaneous insulin infusion.

Coverage of this therapy, **effective for dates of service on or after May 21, 2002**, will be considered under the Region A Durable Medical Equipment Regional Carrier (DMERC A) local medical review policy (LMRP) for external infusion pumps (DMERC A #14.27). Beneficiaries with pulmonary artery hypertension must meet the same coverage criteria as for the administration of parenteral epoprostenol:

A. The pulmonary hypertension is not secondary to pulmonary venous hypertension (e.g., left sided atrial or ventricular disease, left sided valvular heart disease, etc.) or disorders of the respiratory system (e.g., chronic obstructive pulmonary disease, interstitial lung disease, obstructive sleep apnea or other sleep disordered breathing, alveolar hypoventilation disorders, etc.); and

B. The patient has primary pulmonary hypertension or pulmonary hypertension which is secondary to one of the following conditions: connective tissue disease, thromboembolic disease of the pulmonary arteries, human immunodeficiency virus (HIV) infection, cirrhosis, diet drugs, congenital left to right shunts, etc. If these conditions are present, the following criteria must be met:

1. The pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition; and

2. The mean pulmonary artery pressure is greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion; and

3. The patient has significant symptoms from the pulmonary hypertension (i.e., severe dyspnea on exertion, and either fatigability, angina, or syncope); and

4. Treatment with oral calcium channel blocking agents has been tried and failed, or has been considered and ruled out.

Treprostinil should be billed using the miscellaneous drug code J7799. The infusion pump is billed using code K0455 (Infusion pump used for uninterrupted administration of epoprostenol). Code K0455 is reimbursed in the frequent and substantial service payment category, because treprostinil, similar to epoprostenol, requires uninterrupted infusion to avoid potential life-threatening side effects associated with abrupt discontinuation of the drug. Therefore, following the policy established for epoprostenol, Medicare will only pay for one unit of service of K0455. The supplier is responsible for ensuring that there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment, which may include a back-up pump. Payment for this is included in the allowance for code K0455; therefore, a second pump provided and billed separately as a back-up will be denied as not medically necessary.

Supplies for the pump are coded A4221 (Supplies for maintenance of drug infusion catheter, per week, (list drug separately)). Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings, and infusion supplies (excluding the drug reservoir) related to continuous subcutaneous treprostinil infusion. Catheter insertion devices for use with subcutaneous infusions are included in the allowance for code A4221 and are not separately payable. More than one unit of service of code A4221 per week will be denied as not medically necessary.

Code A4232 (Syringe with needle for external insulin pump, sterile, 3 cc) describes the drug reservoir for use with the infusion pump (K0455). The reservoir may be either glass or plastic and includes the needle for drawing up the treprostinil. This code does not include the drug for use in the reservoir.

Procedures Subject to Home Health Consolidated Billing

Update Process to List of Codes

With the publication of Program Memorandum (PM) AB-01-65 in April 2001 (Change Request 1622), the Centers for Medicare & Medicaid Services (CMS) established the process of periodically updating the lists of HCPCS codes which are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). That instruction indicated the lists would be updated annually, in conjunction with the overall annual HCPCS code set update.

CMS has determined that more frequent updates of the HH consolidated billing code lists are necessary. This is to reflect the creation of temporary HCPCS codes ('K' codes) throughout the course of a year, which may describe services subject to consolidated billing. For example, such codes may be created at the request of Durable Medical Equipment Regional Carriers (DMERCs) to reflect new technologies or clarify coding in support of local medical review policies (LMRPs). To account for any mid-year coding changes, CMS will update the HH consolidated billing code lists as frequently as quarterly. Some quarters there may be no update, if no new codes need to be reflected. As with previous updates, the new coding identified in each update will describe the same services which were used to determine the HH PPS payment rates. No additional services, which are not reflected in the HH PPS rates, will be added by these updates.

Current Update

The current update is to reflect a new set of 'K' codes for ostomy supplies, which were published in PM AB-02-001 (Change Request 1993). The following new 'K' codes replace codes currently on the HH consolidated billing code list, **as of October 1, 2002**. Note that each two new codes in the list below replace the same deleted code.

Note: The following abbreviations are used in the code descriptions:

attd	attached
bdr	border
extd	extended
sq in	square inch
stnd	standard
w/	with
w/o	without

New Code and Description

K0561	Non-pectin based ostomy paste
K0562	Pectin based ostomy paste
K0563	Extd wear ostomy skin barrier <4 sq in
K0564	Extd wear ostomy skin barrier >4 sq in
K0565	Ostomy skin barrier w/flange <4 sq in
K0566	Ostomy skin barrier w/flange >4 sq in
K0567	1-piece drainable ostomy pouch
K0568	1-piece convex drainable ostomy pouch
K0570	Ostomy skin barrier w/flange <4 sq in
K0571	Ostomy skin barrier w/flange >4 sq in

Deleted Code and Description

A4370	Skin barrier paste per oz
A4370	Skin barrier paste per oz
A4374	Skin barrier extd wear
A4374	Skin barrier extd wear
A4386	Ostomy skin barrier w/flange extd wear
A4386	Ostomy skin barrier w/flange extd wear
A5061	Pouch drainable w/barrier attd
A5061	Pouch drainable w/barrier attd
A5123	Skin barrier w/flange
A5123	Skin barrier w/flange

The following new 'K' codes are added to the HH consolidated billing code list without a replacement:

K0569	2-piece drainable ostomy pouch
K0574	Ostomy pouch filter
K0575	Ostomy pouch rustle-free material
K0576	Ostomy pouch comfort panel
K0577	Ostomy pouch odor barrier
K0578	Urinary pouch faucet/drain
K0579	Ostomy pouch absorbent material
K0580	Ostomy pouch locking flange

CMS has determined that the following codes, which were published in PM AB-02-001, are **not** subject to HH consolidated billing:

K0572	Non-waterproof tape
K0573	Waterproof tape

The following is the resulting list of 207 non-routine supply codes that replaces the previous list of 194. The list of 194 codes was published in PM AB-01-65 and modified by PM AB-01-128 (Change Request 1854).

A4212	Non coring needle or stylet
A4310	Insert tray w/o bag/catheter
A4311	Catheter w/o bag 2-way latex
A4312	Catheter w/o bag 2-way silicone
A4313	Catheter w/bag 3-way

continued next page...

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A4314	Catheter w/drainage 2-way latex
A4315	Catheter w/drainage 2-way silicone
A4316	Catheter w/drainage 3-way
A4319	Sterile H2O irrigation solution
A4320	Irrigation tray
A4321	Catheter therapeutic irrigation agent
A4322	Irrigation syringe
A4323	Saline irrigation solution
A4324	Male external cathete w/adhesive coating
A4325	Male external catheter w/adhesive strip
A4326	Male external catheter
A4327	Female urinary collection device cup
A4328	Female urinary collection pouch
A4330	Stool collection pouch
A4331	Extension drainage tubing
A4332	Lubricant for catheter insertion
A4333	Urinary catheter anchor device
A4334	Urinary catheter leg strap
A4335	Incontinence supply
A4338	Indwelling catheter latex
A4340	Indwelling catheter special
A4344	Catheter indwelling foley 2 way silicone
A4346	Catheter indwelling foley 3 way
A4347	Male external catheter
A4348	Male external catheter extd wear
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary catheter
A4354	Catheter insertion tray w/bag
A4355	Bladder irrigation tubing
A4356	External ureth clamp or compr device
A4357	Bedside drainage bag
A4358	Urinary leg bag
A4359	Urinary suspensory w/o leg bag
A4361	Ostomy face plate
A4362	Solid skin barrier
A4364	Liquid adhesive for facial prosthesis
A4365	Adhesive remover wipes
A4367	Ostomy belt
A4368	Ostomy filter
A4369	Skin barrier liquid per oz
A4371	Skin barrier powder per oz
A4372	Skin barrier solid 4x4 (4 sq in) equiv
A4373	Skin barrier w/flange
A4375	Drainable plastic pouch w/face plate
A4376	Drainable rubber pouch w/face plate
A4377	Drainable plastic pouch w/o face plate
A4378	Drainable rubber pouch w/o face plate
A4379	Urinary plastic pouch w/face plate
A4380	Urinary rubber pouch w/face plate
A4381	Urinary plastic pouch w/o face plate
A4382	Urinary heavy plastic pch w/o face plate
A4383	Urinary rubber pouch w/o face plate
A4384	Ostomy faceplate/silicone ring
A4385	Ostomy skin barrier solid extd wear
A4387	Ostomy closed pch w/attd stnd barrier
A4388	Drainable pouch w/extd wear barrier
A4389	Drainable pouch w/stnd wear barrier
A4390	Drainable pouch extd wear convex
A4391	Urinary pouch w/extd wear barrier
A4392	Urinary pouch w/stnd wear barrier
A4393	Urine pouch w/extd wear barrier convex
A4394	Ostomy pouch liquid deodorant
A4395	Ostomy pouch solid deodorant
A4396	Peristomal hernia support belt
A4397	Irrigation supply sleeve
A4398	Ostomy irrigation bag
A4399	Ostomy irrigation cone/cath w/barriers
A4400	Ostomy irrigation set
A4402	Lubricant per ounce
A4404	Ostomy ring each
A4421	Ostomy supply misc
A4455	Adhesive remover per ounce
A4460	Elastic compression bandage
A4462	Abdominal dressing holder/binder
A4481	Tracheostoma filter
A4622	Tracheostomy or larngectomy
A4623	Tracheostomy inner cannula
A4625	Tracheostomy care kit for new trach
A4626	Tracheostomy cleaning brush
A4649	Surgical supplies
A5051	Pouch closed w/barrier attd
A5052	Closed ostomy pouch w/o barrier
A5053	Closed ostomy pouch face plate
A5054	Closed ostomy pouch w/flange
A5055	Stoma cap
A5062	Drainable ostomy pouch w/o barrier
A5063	Drainable ostomy pouch w/flange
A5071	Urinary pouch w/barrier
A5072	Urinary pouch w/o barrier
A5073	Urinary pouch on barrier w/flange
A5081	Continent stoma plug
A5082	Continent stoma catheter
A5093	Ostomy accessory convex insert
A5102	Bedside drain bottle w/ w/o tube
A5105	Urinary suspensory
A5112	Urinary leg bag
A5113	Latex leg strap
A5114	Foam/fabric leg strap
A5119	Skin barrier wipes box per 50

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A5121	Solid skin barrier 6x6 (6 sq in)
A5122	Solid skin barrier 8x8 (8 sq in)
A5126	Disk/foam pad w/ w/o adhesive
A5131	Appliance cleaner
A6010	Collagen based wound filler, dry foam
A6020	Collagen wound dressing
A6021	Collagen dressing <=16 sq in
A6022	Collagen dressing>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dressing wound filler
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate dressing >16 <=48 sq in
A6198	Alginate dressing > 48 sq in
A6199	Alginate dressing wound filler
A6200	Composite dressing <=16 sq in no bdr
A6201	Composite dressing >16<=48 no bdr
A6202	Composite dressing >48 sq in no bdr
A6203	Composite dressing <= 16 sq in
A6204	Composite dressing >16<=48 sq in
A6205	Composite dressing > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam dressing <=16 sq in w/o bdr
A6210	Foam dressing >16<=48 sq in w/o bdr
A6211	Foam dressing > 48 sq in w/o bdr
A6212	Foam dressing <=16 sq in w/bdr
A6213	Foam dressing >16<=48 sq in w/bdr
A6214	Foam dressing > 48 sq in w/bdr
A6215	Foam dressing wound filler
A6219	Gauze <= 16 sq in w/bdr
A6220	Gauze >16 <=48 sq in w/bdr
A6221	Gauze > 48 sq in w/bdr
A6222	Gauze <=16 in no water/saline w/o bdr
A6223	Gauze >16<=48 no water/sal w/o bdr
A6224	Gauze > 48 in no water/sal w/o bdr
A6228	Gauze <= 16 sq in water/saline
A6229	Gauze >16<=48 sq in water/saline
A6230	Gauze > 48 sq in water/saline
A6231	Hydrogel dressing<=16 sq in
A6232	Hydrogel dressing>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6234	Hydrocolloid dressing <=16 in w/o bdr
A6235	Hydrocolloid dressing >16<=48 w/o bd
A6236	Hydrocolloid dressing > 48 in w/o bdr
A6237	Hydrocolloid dressing <=16 in w/bdr
A6238	Hydrocolloid dressing >16<=48 w/bdr
A6239	Hydrocolloid dressing > 48 in w/bdr
A6240	Hydrocolloid dressing filler paste
A6241	Hydrocolloid dressing filler dry
A6242	Hydrogel dressing <=16 in w/o bdr
A6243	Hydrogel dressing >16<=48 w/o bdr
A6244	Hydrogel dressing >48 in w/o bdr
A6245	Hydrogel dressing <= 16 in w/bdr
A6246	Hydrogel dressing >16<=48 in w/bdr
A6247	Hydrogel dressing > 48 sq in w/bdr
A6248	Hydrogel dressing gel filler
A6251	Absorptive dressing <=16 sq in w/o bdr
A6252	Absorptive dressing >16 <=48 w/o bdr
A6253	Absorptive dressing > 48 sq in w/o bdr
A6254	Absorptive dressing <=16 sq in w/bdr
A6255	Absorptive dressing >16<=48 in w/bdr
A6256	Absorptive dressing > 48 sq in w/bdr
A6257	Transparent film <= 16 sq in
A6258	Transparent film >16<=48 in
A6259	Transparent film > 48 sq in
A6261	Wound filler gel/paste /oz
A6262	Wound filler dry form / gram
A6266	Impregnated gauze no water/saline/yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6405	Sterile elastic gauze /yd
A6406	Sterile non-elastic gauze/yd
A7501	Tracheostoma valve w/diaphragm
A7502	Replacement diaphragm/face plate
A7503	HMES filter holder or cap
A7504	Tracheostoma HMES filter
A7505	HMES or trach valve housing
A7506	HMES/trachvalve adhesivedisk
A7507	Integrated filter & holder
A7508	Housing & Integrated Adhesiv
A7509	Heat & moisture exchange system
K0561	Non-pectin based ostomy paste
K0562	Pectin based ostomy paste
K0563	Extd wear ostomy skin barrier <4 sq in
K0564	Extd wear ostomy skin barrier >4 sq in
K0565	Ostomy skin barrier w/flange <4 sq in
K0566	Ostomy skin barrier w/flange >4 sq in
K0567	1 piece drainable ostomy pouch
K0568	1 piece convex drainable ostomy pouch
K0569	2 piece drainable ostomy pouch
K0570	Ostomy skin barrier w/flange < 4sq in
K0571	Ostomy skin barrier w/flange >4 sq in
K0574	Ostomy pouch filter
K0575	Ostomy pouch rustle free material
K0576	Ostomy pouch comfort panel
K0577	Ostomy pouch odor barrier

continued next page...

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K0578	Urinary pouch faucet/drain
K0579	Ostomy pouch absorbent material
K0580	Ostomy pouch locking flange

The list of 69 therapy codes that are subject to HH consolidated billing is unaffected by this update. These codes were also published in PM AB-01-65, which was published in the September 2001 edition of the *DMERC Medicare News*.

[Reference: Change Request (CR) 2247; Transmittal AB-02-092]

Claims for Medicare Beneficiaries in State or Local Custody Under a Penal Authority

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does **not** pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

The Centers for Medicare & Medicaid Services (CMS) presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody. **However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of the QJ modifier.**

Effective January 1, 2003, the Durable Medical Equipment Regional Carriers (DMERCs) must deny claims identified by the Common Working File (CWF) as non-covered under 42 CFR 411.4(a) and 411.4(b). These non-covered charges will be adjudicated with Remark Code N103: "Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt."

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

[Reference: Change Request (CR) 2022; Transmittal AB-02-097]

Updates to the Place of Service (POS) Code Set

The following represents the current POS code set accepted by Medicare. An asterisk (*) flags new codes, which are **effective January 1, 2003**. In addition, this listing indicates whether services in a given setting are to be paid at the facility (=F) or nonfacility (=NF) rate.

POS Code/*Name* Description	**Payment Rate**	**Crosswalk To**
01-02 /*Unassigned*		**N/A**
03* /*School*	**NF**	**11/*Office***
A facility whose primary purpose is education.		
04* /*Homeless Shelter*	**NF**	**11/*Office***
A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).		

POS Code/*Name* Description	Payment Rate	Crosswalk To
09-10 /*Unassigned*		--
11 /*Office*	**NF**	--

Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12 /*Home*	**NF**	--

Location, other than a hospital or other facility, where the patient receives care in a private residence.

13-14 /*Unassigned*		--
15* /*Mobile Unit*	**NF**	**11/*Office***

A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

16-19 /*Unassigned*		--
20* /*Urgent Care Facility*	**NF**	**11/*Office***

Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21 /*Inpatient Hospital*	**F**	--

A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22 /*Outpatient Hospital*	**F**	--

A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23 /*Emergency Room - Hospital*	**F**	--

A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

POS Code/*Name* Description	Payment Rate	Crosswalk To
24 /*Ambulatory Surgical Center*	**F** (Note: pay at the nonfacility rate for payable procedures not on the ASC list)	--

A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

25 /*Birthing Center*	**NF**	--

A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.

26 /*Military Treatment Facility*	**F**	--

A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

27-30 /*Unassigned*		--
31 /*Skilled Nursing Facility*	**F**	--

A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32 /*Nursing Facility*	**NF**	--

A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33 /*Custodial Care Facility*	**NF**	--

A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34 /*Hospice*	**F**	--

A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

35-40 /*Unassigned*		--

continued next page...

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POS Code/*Name* Description	Payment Rate	Crosswalk To
41 /*Ambulance-Land*	**F**	**--**

A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42 /*Ambulance-Air or Water*	**F**	**--**

An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

43-49 /*Unassigned*		**--**

50 /*Federally Qualified Health Center*	**NF**	**--**

A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

51 /*Inpatient Psychiatric Facility*	**F**	**--**

A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52 /*Psychiatric Facility - Partial Hospitalization*	**F**	**--**

A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

53 /*Community Mental Health Center*	**F**	**--**

A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

POS Code/*Name* Description	Payment Rate	Crosswalk To
54 /*Intermediate Care Facility/Mentally Retarded*	**NF**	**--**

A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55 /*Residential Substance Abuse Treatment Facility*	**NF**	**--**

A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56 /*Psychiatric Residential Treatment Center*	**F**	**--**

A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57-59 /*Unassigned*		**--**

60 /*Mass Immunization Center*	**NF**	**--**

A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

61 /*Comprehensive Inpatient Rehabilitation Facility*	**F**	**--**

A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62 /*Comprehensive Outpatient Rehabilitation Facility*	**NF**	**--**

A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

POS Code/*Name* Description	Payment Rate	Crosswalk To
63-64 /*Unassigned*		--
65 /*End-Stage Renal Disease Treatment Facility*	**N(*)**	--
A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.		
66-70 /*Unassigned*		--
71 /*State or Local Public Health Clinic*	**NF**	--
A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.		
72 /*Rural Health Clinic*	**NF**	--
A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.		
73-80 /*Unassigned*		--
81 /*Independent Laboratory*	**NF**	--
A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.		
82-98 /*Unassigned*		--
99 /*Other Place of Service*		--
Other place of service not identified above.		

[Reference: Change Request (CR) 2259; Transmittal B-02-055]

(*) Published as received from the Centers for Medicare & Medicaid Services (CMS).

A correction will appear in the December 2002 edition of the *DMERC Medicare News*.

Billing Prosthetics and Orthotics - HCPCS Updates

The following codes listed below are being added to the Healthcare Common Procedure Coding System (HCPCS) **effective October 1, 2002**. These codes fall under the fee schedule category for prosthetics and orthotics. These codes replace codes L5660, L5662, L5663, and L5664, which are invalid for Medicare use effective October 1, 2002.

Code	Descriptor
K0556	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
K0557	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
K0558	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)
K0559	Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557)

In addition, suppliers may be inappropriately billing socket design codes L5647 (for a below knee prosthesis) and L5652 (for an above knee prosthesis) each time a replacement socket insert (codes L5660, L5662, L5663, or L5664) is furnished. The socket design code (L5647 or L5652) should be billed **only** at the time that the **initial** prosthesis is furnished to the patient, and not every time a replacement socket insert is furnished. Suppliers billing in such a manner must stop this practice **immediately**.

[Reference: Change Request (CR) 2245; Transmittal AB-02-104]

Jurisdiction Change for Disposable Hyperbaric Oxygen Chambers

Effective for **dates of service on or after January 1, 2003**, the jurisdiction for HCPCS code A4575 (topical hyperbaric oxygen chamber, disposable) will change from local carriers to the Durable Medical Equipment Regional Carriers (DMERCs).

In accordance with instructions in the Coverage Issues Manual §35-10 (D), claims for topical hyperbaric oxygen will continue to be denied as not medically necessary.

[Reference: Change Request (CR) 2177; Transmittal B-02-044]

Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Medicare providers can begin to use the 2002 revised/new ICD-9-CM codes **for claims submitted on or after October 1, 2002**. Both the old and new ICD-9-CM codes will be accepted for dates of service October 1, 2002 through December 31, 2002; however, it is important for providers to use the most recent version of the ICD-9-CM coding book and to code to the highest level of specificity.

Providers can access the new, revised and deleted ICD-9-CM codes on the Centers for Medicare & Medicaid Services (CMS) Web site at *www.cms.hhs.gov/medlearn/icd9code.asp*.

To obtain the latest code book, or obtain the latest code revisions in electronic form, you can contact one of the following medical publishers:

- **Governement Printing Office:** 866-512-1800
- **Ingenix:** 800-765-6588
- **American Medical Association:** 800-621-8335

Note: This is not intended as an all-inclusive list of medical publishers.

[Reference: Change Request (CR) 2194; Transmittal AB-02-085]

HIPAA

ICD-9-CM Codes Using Date of Service and Not Date of Receipt

According to the Health Insurance Portability and Accountability Act (HIPAA), national code sets must be date of service compliant. In order for Medicare carriers to be HIPAA compliant, all carriers must be able to process the annual update of ICD-9-CM codes based on date of service instead of date of receipt. Therefore, **effective for all claims received on or after January 1, 2003** [Editor's Note: for dates of services on and after October 1, 2002], the Region A Durable Medical Equipment Regional Carrier (DMERC A) will be verifying the validity of diagnosis codes based on the date of service of the procedure code to which the diagnosis code is correlated. This change means that providers and their billing staff will need to know which **diagnosis code is in effect at the time the services are rendered**. This instruction does not change the number of diagnosis codes that may be submitted (up to four in the header plus the line item); it only requires that diagnosis codes be submitted and processed using the date of service and not the date of receipt. Diagnosis codes will be processed in a fashion similar to HCPCS codes (by date of service).

A 90-day grace period will apply. For claims for dates of service October 1, 2002, through December 31, 2002, both the old and the updated ICD-9-CM codes will be accepted.

[Reference: Change Request (CR) 2209, Transmittal B-02-045]

Remittance Advice Coding and Health Insurance Portability and Accountability Act (HIPAA) Transaction 835v4010 Completion Update

Program Memorandum (PM) Transmittal AB-02-067 (Change Request 1959; dated May 2, 2002) updates remark and reason codes for Medicare Part A, B and

Durable Medical Equipment (DME) claims and updates the Medicare carrier flat files.

X12N 835 Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of remittance advice remark codes used by both Medicare and non-Medicare entities. The list of remark codes is updated continuously as needed, and both Medicare and non-Medicare entities can request new codes or modifications in the existing codes to address their business needs. Some of these changes may not affect Medicare.

The list of remark codes is available at *www.wpc-edi.com/hipaa*. The list is updated each March, July, and November. Download the list from this Web site during those three months to obtain the most current set of approved remark codes. The following list summarizes changes made through February 28, 2002:

Code	Current Narrative	Type of Change
MA01	(Initial Part B determination, Medicare carrier or intermediary)--If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice,unless you have a good reason for being late. If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.	**Modification**
MA02	(Initial Medicare Part A Determination) --If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a Peer Review Organization (PRO) must be appealed to that PRO. (An institutional provider,e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.)	**Modification**
MA03	(Medicare Hearing)--If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.	**Modification**
MA126	Pancreas transplant not covered unless kidney transplant performed.	**New Code**
N23	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.	**Modification**
N70	Home health consolidated billing and payment applies.	**Modification**
N71	Your unassigned claim for a drug or biological or clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.	**Modification**
N73	A SNF is responsible for payment of outside providers who furnish these services/supplies to residents. Only the professional component of physician services can be paid separately.	**Modification**
N95	This provider type may not bill this service.	**New Code**
N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.	**New Code**
N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.	**New Code**
N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.	**New Code**
N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.	**New Code**

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N100	PPS code corrected during adjudication.	**New Code**
N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the Provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	**New Code**
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	**New Code**
N103	Social Security records indicate that this beneficiary was a prisoner when this claim was submitted. Medicare does not cover items and services furnished to beneficiaries while they are incarcerated, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated.	**New Code**
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at *www.cms.gov*.	**New Code**
N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.	**New Code**
N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.	**New Code**
N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They can not be billed separately as outpatient services.	**New Code**
N108	This item/service was denied because the upgrade information was invalid.	**New Code**
N109	This claim was chosen for complex review and was denied after reviewing the medical records.	**New Code**
N110	This facility is not certified for film mammography.	**New Code**
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**New Code**
N112	This claim is excluded from your electronic remittance advice.	**New Code**

X12 N 835 Health Care Claim Adjustment Reason Codes

The committee that maintains the health care claim adjustment reason codes, a non-CMS body, meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at *www.wpc-edi.com/hipaa*.

A reason code may be retired if determined to be duplicative or no longer applicable. These changes are always effective with a specified 835 future version, and never retroactively. Remark and reason code changes, other than retirements, are not version specific. The committee did not approve any reason code changes in October 2001. The committee approved the following reason code changes in February 2002:

Reason codes 16, 17 and 125 will have an additional sentence added to their current descriptions that reads: Additional information is supplied using the "Remittance Advice Remark Codes" whenever appropriate.

Changes in X12N 835 Flat File and Companion Document

There have been a few changes in the 835 Flat File issued with Transmittal AB-01-132, dated September 21, 2001 (Change Request 1828). These changes have been made to make the 835 Flat File more consistent with the 837 Flat File for carriers. The updated X12N 835 version 4010 supportive remittance advice Flat File is posted at *www.hcfa.gov/medicare/edi/hipaadoc.htm* under the file name B835v4010-3.xls and dated March 8, 2002. Subsequent adjustments may be issued if necessary to resolve problems or errors identified during programming or testing. The most current version of the X12N 835 version 4010 Flat File includes the following changes:

Element	Identifier	Description of change
NM1	NM109	Previous description changed from Patient control # to HIC # NSF reference changed from 400-03 to 400-07
MOA	MOA01	PIC changed from S9(7)V99 to 9(3)V99
CAS	CAS04	PIC changed from S9(3)V99 to 9(7)
	CAS07	PIC changed from S9(3)V99 to 9(7)
	CAS10	PIC changed from S9(3)V99 to 9(7)
	CAS13	PIC changed from S9(3)V99 to 9(7)
	CAS16	PIC changed from S9(3)V99 to 9(7)
	CAS19	PIC changed from S9(3)V99 to 9(7)

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There is no change in the companion document in conjunction with these changes in the 835 carrier Flat File.

Implementation of the National Council for Prescription Drug Programs (NCPDP) Standard for Retail Pharmacy Drug Transactions

The Secretary of the Department of Health and Human Services has established, under part 162 of title 45 of the Code of Federal Regulations, the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Version 5.1 and Batch Standard 1.1 as the standard for electronic retail pharmacy drug claims and coordination of benefits (COB). This standard will be used by all health plans, including Durable Medical Equipment Regional Carriers (DMERCs) that process retail pharmacy drug transactions.

In order to comply with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions, DMERCs and their standard system must complete implementation of these NCPDP standards by October 16, 2003. Further information on the HIPAA standards requirements in general may be obtained at *aspe.hhs.gov/admnsimp*. Individuals who want to review the NCPDP standard implementation guides can obtain them at *www.ncpdp.org* for a fee of $450.00.

[Reference: Change Request (CR) 2255; Transmittal B-02-052]

More information will appear in future editions of the *DMERC Medicare News* and on the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site at *www.umd.nycpic.com*.

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/emc&hipaa.html*.

Medical Policy

Publication of Final Local Medical Review Policies (LMRPs)

Beginning October 1, 2002, the Region A Durable Equipment Regional Carrier (DMERC A) will no longer be required, by the Centers for Medicare & Medicaid Services (CMS), to distribute full-text local medical review policies (LMRPs) to all providers via hardcopy. Therefore, the Medical Policies update can be retrieved through our Web site at *www.umd.nycpic.com*. Once there, click on "DMERC," then click on "Medical Policies," under "Suppliers." After accepting the CPT License Agreement, click on "Region A Final Medical Review Policies" and link to the Program Safeguard Contractor (PSC) Web site (*www.tricenturion.com*), where you can access the entire selection of LMRPs.

Notification of the Medical Policies update will be via an article in the *DMERC Medicare News* bulletin and a message posted to the ListServe. Providers/suppliers without Internet access can request hardcopy versions by submitting a request in writing to: HealthNow New York Inc., Attention: Program Inquiries, P.O. Box 6800, Wilkes-Barre, PA 18773-6800.

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* [follow the steps in the above article to access the LMRPs].

A brief summary of the major changes in each LMRP is described. Suppliers are advised to review each LMRP for complete details.

Home Blood Glucose Monitors

(*Effective for dates of service on or after October 1, 2002*)

- Revised definitions of order renewal and order refill
- Clarified coverage of E2101 for beneficiaries with manual dexterity impairments is not dependent on visual impairment
- Emphasized that suppliers have an obligation to monitor a beneficiary's utilization of supplies and dispense supplies accordingly

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- Stated specific elements required for orders
- Clarified the DMERC position on the use of data collection forms
- Removed bundling table

Oral Anti-Cancer Drugs
(*Effective for dates of service on or after October 1, 2002*)
- Updated list of NDC codes
- Added HCPCS codes A9270 and J8999 and instructions for their use

Local Medical Review Policy (LMRP) Reconsideration Process

The Local Medical Review Policy (LMRP) Reconsideration Process is a mechanism by which interested parties can request a revision of an LMRP. In order to be considered a valid request, the following requirements must be met:

- Requestor must be qualified;
- Subject must be appropriate;
- Information submitted must be adequate; and
- Process for submission must be followed.

Any request for LMRP reconsideration that, in the judgment of the Region A Durable Equipment Regional Carrier Program Safeguard Contractor (DMERC PSC), does not meet these requirements is invalid.

Requestor
The DMERC PSC will consider all LMRP reconsideration requests from:

- Beneficiaries residing in our jurisdiction; or
- Suppliers doing business in our jurisdiction.

We may consider LMRP reconsideration requests from any other interested party doing business in our jurisdiction.

Subject
The LMRP Reconsideration Process is available only for **final** LMRPs. The whole LMRP or any part of the LMRP may be reconsidered. Requests are not accepted for other documents including:

- National Coverage Decisions (NCD) – for example, Coverage Issues Manual;
- Coverage provisions in interpretive manuals – for example, Medicare Carrier Manual;
- Draft LMRPs;
- Retired LMRPs;
- Individual claim determinations;
- Bulletins, articles, training materials;
- Any instance in which no LMRP exists, i.e. requests for development of an LMRP.

If modification of the LMRP would conflict with an NCD, the request is not valid. Refer to the NCD reconsideration process at *www.cms.hhs.gov/coverge/8a1.asp.*

Information to be Submitted
The request must identify the language that the requestor wants added to or deleted from an LMRP. Requests must include a justification supported by new evidence, which may materially affect the LMRP's content or basis. When articles or textbooks are cited, copies of the published documents must be included.

The level of evidence required for LMRP reconsideration is the same as that required for new/revised LMRP development. As described in the Medicare Program Integrity Manual (PIM), LMRPs are to be based on the strongest evidence available. In order of preference, LMRPs are based on:

- Published authoritative evidence derived from definitive randomized clinical trials or other definitive studies;
- General acceptance by the medical community (standard of practice), as supported by sound medical evidence based on:
  - Scientific data or research studies published in peer-reviewed medical journals; or
  - Consensus of expert medical opinion (e.g., recognized authorities in the field); or
  - Medical opinion from medical associations or other health care experts.

Acceptance by individual health care providers, or even a limited group of health care providers, normally does not indicate general acceptance by the medical community. Testimonials indicating such limited acceptance, and limited case studies distributed by sponsors with financial interest in the outcome, are not sufficient evidence of general acceptance by the medical community. The broad range of available evidence will be considered and its quality will be evaluated before a conclusion is reached.

Submission Process

In order to be valid, the request for LMRP reconsideration must be in writing and must include the name and mailing address of the requestor. Inclusion of a telephone number and/or email address is optional. If the requestor is a supplier, the supplier number must be included. If the requestor is neither a beneficiary nor a supplier, the requestor must identify the nature of their business and whom they are representing (if applicable).

Requests may be submitted by mail, email, or fax to:

Paul J. Hughes, MD, Medical Director
DMERC Region A PSC
Tricenturion, LLC
7909 Parklane Road, Suite 190
Columbia, SC 29223

dmerca.lmrp.recon@tricenturion.com

Fax 803-264-7788

[Editor's Note: Due to privacy and security regulations, supplier numbers cannot be submitted with email requests.]

DMERC Response

Within 30 days after the request is received, the DMERC PSC will determine whether the request is valid or invalid and will notify the requestor of that determination. If the request is invalid, the DMERC PSC will explain why it is invalid.

If the request is valid, within 90 days after the request is received, the DMERC PSC will make a reconsideration decision and will notify the requestor of the decision with its rationale. Decision options include: no revision, revision to a less restrictive policy, revision to a more restrictive policy, or retiring the policy.

Any revision to the policy will then be published in a **future** update to the *DMERC A Supplier Manual.*

[Reference: Change Request (CR) 2196; Transmittal 28]

[Editor's Note: Claims adjudication is based on the effective date of the policy update, not when the LMRP reconsideration determination has been made by the DMERC PSC.]

New Medicare Medical Review Guidelines for Claims for Diabetic Testing Supplies

Per Change Request 2133 (Transmittal B-02-037; dated June 7, 2002), the following guidelines have been established for the Durable Medical Equipment Regional Carriers (DMERCs) to use when processing claims for diabetic testing supplies:

I. General Requirements

A. An order to **refill** is the act of replenishing quantities of previously ordered items during the time period in which the current order is valid. An order refill does not have to be approved by the ordering physician as it is assumed that the ordering physician has approved that quantity of product.

B. An order **renewal** is the act of obtaining an order for an additional period of time beyond that previously ordered by the physician.

II. Physician Requirements

A. Claims for diabetic testing supplies **must** be supported by a valid order. The order may be in the form of a written, faxed, or electronic order and must state to the supplier:

1. The item(s) to be dispensed;

2. The quantity of item(s) to be dispensed;

3. The frequency of testing ("as needed" is **not** acceptable);

4. Whether the patient has insulin-treated or non-insulin-treated diabetes;

5. A physician signature;

6. A signature date; and,

7. A start date of the order – only required if the start date is different than the signature date.

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B. For verbal orders, the physician **must** sign and return to the supplier a written, faxed, or electronic confirmation of the verbal order. On this confirmation the item(s) to be dispensed, frequency of testing, and start date (if applicable) may be written by the supplier, but the confirmation **must** be reviewed, signed, and dated by the physician. Orders are valid for up to 12 months if the physician does not indicate an earlier expiration date.

C. Renewal orders **must** contain the same information as initial orders and be submitted to the supplier using one of the methods acceptable for initial orders.

D. We expect that physician records will reflect the care provided to the patient including, but not limited to evidence of the medical necessity for the prescribed frequency of testing. Physicians are **not** required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DMERC.

III. Supplier Requirements

A. If a DMERC requests a supplier to justify quantity billed, the supplier **must** provide all documentation listed in Section II, A. above and any other information requested by the DMERC. At the beneficiary's request, suppliers may refill orders without consulting the treating physician; so long as the order remains valid and allows for refills. Under **no** circumstances may suppliers automatically dispense supplies on a predetermined basis; even if the beneficiary has "authorized" this in advance.

B. Upon expiration of the order, the supplier may contact the physician to renew the order. However, the request for renewal may only be made with the beneficiary's continued monthly use of the supply and only with the beneficiary's request for refill or renewal.

C. A supplier may **not** dispense more than a 3-month supply of diabetic testing supplies at a time. Suppliers should **not** dispense a quantity of supplies exceeding a beneficiary's expected utilization (e.g., testing once a day would require approximately 100 strips in a 3-month period).

D. Suppliers share responsibility for providing care that is reasonable and necessary. To this end, suppliers should only provide supplies in quantities needed and at appropriate times. Suppliers should also stay attuned to atypical utilization patterns on behalf of their clients and verify with ordering physicians that the atypical utilization is, in fact, warranted.

E. In response to DMERC requests, suppliers may need to collect specific information from physicians in order to corroborate the care provided. While we do **not** prohibit suppliers from creating data collection forms in order to gather this information, the DMERCs will **not** rely on these forms to prove the medical necessity of services provided. The DMERCs should expect physician notes, prescriptions, and medical charts to corroborate the care provided. Suppliers should assure that they do **not** attribute any self-generated forms or data collection requests to the Medicare Program, the Centers for Medicare & Medicaid Services (CMS), or the DMERCs.

IV. DMERC Requirements

DMERCs retain the authority to review claims and other documentation in order to verify that the care provided was reasonable and necessary.

Repairs Policy – Retired

The current Durable Medical Equipment Regional Carrier (DMERC) local medical review policy (LMRP) on Repairs (DMERC A #14.12) is being retired **effective for dates of service on or after October 1, 2002**. A revised policy containing updated information will be published in a future *DMERC A Supplier Manual* update.

[Editor's Note: This applies only to HCPCS code **E1350** (Repair of nonroutine service (e.g., breaking down sealed components) requiring the skill of a technician), not to HCPCS code E1340 (Repair or Non-routine Service).]

Miscellaneous

New Call Center Hours

Effective October 1, 2002, the Region A Durable Medical Equipment Regional Carrier's call center hours will be changing to **8:00 a.m. - 4:00 p.m.** This change will affect the hours callers can reach a telephone representative when calling the provider toll-free line, 866-419-9458, as well as our beneficiary toll-free lines.

DNF – "Do Not Forward" Initiative Also Affects Suppliers Who Are Paid Via Electronic Funds Transfers

The Centers for Medicare & Medicaid Services (CMS) issued a Program Memorandum (Transmittal B-02-023; Change Request 2038) on April 12, 2002, with regard to the Do Not Forward (DNF) Initiative. **Effective October 1, 2002**, checks will not be the only mail sent to the supplier's "Pay To" address in a "Return Service Requested" envelope. **All remittance notices** will also be sent in these envelopes. Any suppliers that are being paid via electronic funds transfer (EFT) **will** be affected. **CMS 21 Supplier Standard #2 states that suppliers must notify the National Supplier Clearinghouse (NSC) of any changes to their supplier file within 30 days of the change. If you have moved and haven't yet sent in a Change of Information form, be sure to get your new address in to the NSC immediately. Don't wait until your payments are suspended.**
Currently, anytime a check is sent to a supplier's "Pay To" address, it is sent in an envelope marked "Return Service Requested." This means, "Do Not Forward." The US Postal Service returns it to the Durable Medical Equipment Regional Carrier (DMERC) if the supplier is no longer at that location. On October 1, 2002, this will also happen for remittance notices. Here is the DNF process:

The DMERC, upon receiving a "Return Service Requested" envelope back,

- places a DNF code on the file,
- suspends payments, and
- notifies the NSC that the "Pay To" address is not correct for that supplier number.

The NSC

- places a DNF code in its system,
- transmits the code to all DMERCs so that they can also suspend payments to that supplier number, and
- attempts to contact the supplier.

The Supplier

- must verify its address in writing. (This means sending in a CMS-855S form to verify its address if there was no change and the mail was returned to the DMERC in error, or to update its supplier file with the new address.)
  - ❖Go to the NSC Web site for step-by-step instructions on using the CMS-855S form as a "Change of Information" form. Visit: *www.palmettogba.com/palmetto/Other.nsf/$$ViewTemplate+for+Docs?ReadForm&Other+Medicare+Partners/National+Supplier+Clearinghouse/FAQs*

The NSC, after receiving the Change of Information form,

- processes the change,
- removes the DNF code, and
- transmits the code removal to all DMERCs so that the DMERCs may resume payment of claims.

If the supplier cannot be reached or fails to send in the CMS-855S form within 35 days of the postmark date on the envelope, the supplier number will be inactivated. The supplier will then have to go through the "reactivation" process, which may take up to 60 days. **To avoid that scenario, send your changes in now.**

National Supplier Clearinghouse Now Doing Online Workshops On the CMS-855S Application Form

The National Supplier Clearinghouse (NSC) is doing an online workshop on the CMS-855S application form. This interactive workshop is free of charge and available for suppliers to take advantage of from the convenience of their homes or offices. The purpose of this workshop is to take the dread and confusion out of using this form, and it walks a supplier through the process step by step.

The NSC will be doing this workshop every couple of weeks, depending on attendance. Anyone attending can

continued next page...

log in to the NSC Web site and download the program (at no cost). Every Friday, the NSC does a Workshop Check-In Session. This allows the supplier to download the program, work out any glitches with his/her computer, and get familiar with it prior to the workshop. Once a supplier has done this, it won't ever have to be done again. The supplier can attend any NSC online workshop by just enrolling after that. (A supplier can attend by simply enrolling and downloading the program on the day of the workshop, but if there are any glitches, there won't be a technical person on hand to assist the supplier.) If the NSC finds that it's starting to get a high attendance for this workshop, it will do it a little more often.

To go to the Check-In Session or enroll for a NSC workshop, the supplier needs to go to the online workshop folder. Visit:
www.palmettogba.com/palmetto/OnlineWorkshops.nsf/$$ViewTemplate+for+ws_oth_nsc?ReadForm
Once in there, the supplier can click on a Check-In Session or enroll in one of the workshops by clicking on "Enroll or Attend" and following the directions. When the workshop day arrives, the enrolled supplier can go here and "attend." Suppliers, who are needing to change information (including addresses), re-enroll or reactivate their numbers, enroll another location under their tax ID, or enroll for the first time, are encouraged to attend this workshop.

Appeal Messages on Medicare Summary Notice (MSN) and Medicare Remittance Notice

Medicare Carriers Manual (MCM) §12000 and 42 CFR 405.803 explain the Medicare Part B administrative appeal process available to beneficiaries and physicians/suppliers with initial determinations. An initial determination is the first adjudication (decision) made by Durable Medical Equipment Regional Carriers (DMERCs) following a request for Medicare payment for an item or supply. A notice of initial determination provides appropriate appeals information to the parties.

The DMERC Standard System issues appeal messages for duplicate service/item denials (including previously denied claims). The Centers for Medicare & Medicaid Services (CMS) has determined that appeal rights should be afforded to the initial determination for a service/item only. Duplicate services/items must not be afforded appeal rights. Therefore, **effective January 1, 2003**, Program Memorandum (PM) Transmittal B-02-047 (Change Request 1986, released on July 24, 2002) instructs the DMERCs to do the following:

- The DMERC Standard System will identify duplicate services/items.
- The DMERCs will stop issuing/printing appeal messages on Medicare Summary Notices (MSNs) and Remittance Notices for duplicate services/items. The MA01 message will not be issued/printed on Remittance Notices in this situation.
- The MSN form, standard paper remittance formats, and the electronic remittance formats will not be changed. This instruction only applies to the message section of the MSN and remark code reporting on remittance notices.
- Only the appropriate duplicate message will print on the MSN/Remittance Notice.
- If a service/item is proved not to be a duplicate, DMERCs will adjudicate the service/item.
- New Messages:
  MSN # 7.3 – This service/item is a duplicate of a previously processed service. No appeal rights are attached to the denial of this service except for the issue as to whether the service is a duplicate. Disregard the appeals information on this notice unless you are appealing whether the service is a duplicate.
  Remark Code N111 – This service was included in a claim that was previously billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate.

Claim Submission Errors for the Third Quarter of Fiscal Year 2002

Claim Submission Errors (CSEs) are errors made by suppliers on a claim form that would cause the claim to reject upon submission to the Region A Durable Medical Equipment Regional Carrier (DMERC A). As part of the reporting requirements by the Centers for Medicare & Medicaid Services (CMS), the DMERC A must tally and analyze data related to CSEs. The Data and Practice Analysis (DAPA) Team at the DMERC has performed an analysis related to the top ten CSEs for the third quarter of fiscal year 2002, which runs from April 1, 2002, to June 30, 2002. During this timeframe, there were **91,702**

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: Insured's ID number is invalid. This is Item 1A of the HCFA-1500 claim form and the DA0-18 record of the electronic claim. **Correction:** Enter the patient's Medicare Health Insurance Claim Number (HICN), whether Medicare is the primary or secondary insurer. **Number of Errors:** There were 6,493 claims submitted without the patient's HICN number.

2.) Error: Referring physician's UPIN is missing. This is Item 17A of the HCFA-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 at *www.umd.nycpic.com/dmprovinfo.html* (UPIN Directory link). **Number of Errors:** There were 4,790 claims submitted without the physician's UPIN number.

3.) and 4.) Error: Part of the Other Carrier's Name and Address (OCNA) number is missing or invalid. These are Items 9 and 11 of the HCFA-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 at *www.umd.nycpic.com/OCNA_01-02.html.* **Number of Errors:** There were 4,579 claims submitted without the OCNA number.

5.) Error: Service "from" and "to" dates cannot span years. These dates are found in Item 24A of the HCFA-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 3,548 claims submitted with incorrect "from" and "to" dates.

6.) Error: Beneficiary's address is invalid. This is Item 5 of the HCFA-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 Item 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 (e.g., APT_4). **Number of Errors:** There were 3,220 claims submitted with incorrect beneficiary addresses.

7.) Error: Beneficiary's zip code is invalid. This is Item 5 of the HCFA-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 Item 5. For the electronic claim: Enter the zip code in the CA0-16 record. **Number of Errors:** There were 3,081 claims submitted without the proper beneficiary zip code.

8.) Error: The HCPCS/Procedure Code you are billing is invalid for the DMERC. This is Item 24D of the HCFA-1500 claim form and the FA0-9 record of the electronic claim. **Correction:** Enter a valid HCPCS/Procedure Code for the DMERC. **Number of Errors:** There were 2,456 claims submitted with an incorrect HCPCS/Procedure Code.

9.) Error: Invalid service dates. These dates are found in Item 24A of the HCFA-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 2,285 claims rejected because of inaccurate service dates.

10.) Error: Invalid Enrollment Form. The Electronic Data Interchange (EDI) Department does not have a valid EDI enrollment form on file for the NSC/provider number you are billing. This only pertains to electronic claims (BA0-205). **Correction:** Before billing electronic claims, make sure you have submitted the enrollment form to the EDI Department. **Number of Errors:** There were 1,741 claims rejected because of an invalid EDI enrollment form on file.

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 ensure 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.

Post Office Boxes

Currently, the Region A Durable Medical Equipment Regional Carrier (DMERC A) has the following post office boxes available:

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

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

Accounting
HealthNow New York Inc.
DMERC A
P.O. Box 6900
Wilkes-Barre, PA 18773-6900

We will be instituting additional post office boxes in the future for claims, appeals and correspondence. This initiative, to direct mail to the process level, will expand upon the current post office boxes and allow for a more efficient distribution of all incoming mail. Information identifying the appropriate post office boxes for which claims, appeals and correspondence should be sent will be included in future DMERC communications.

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.