DMERC Medicare News

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The enclosed information was current at the time of publication. Please visit our Web site for recent updates.

Articles are identified by area of interest as follows: **DRU** = Drugs, **GEN** = General, **MOB** = Mobility/Support Surfaces, **OXY** =Oxygen, **PEN** = Parenteral/Enteral Nutrition, **SPE** = Specialty Items (including orthotics & prosthetics)

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

CMS CENTERS for MEDICARE & MEDICAID SERVICES

DMERC A
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A New Look for the *DMERC Medicare News* Bulletin

As you've probably noticed, the *DMERC Medicare News* bulletin has a new look. In addition to a new design, we've also enhanced the method for categorizing and organizing the content of the bulletin to make it more user-friendly.

For easier reference, as in the past, articles are grouped into categories based on their subject matter, i.e., Billing, EDI & HIPAA (Electronic Data Interchange & Health Insurance Portability and Accountability Act), Miscellaneous, Program Education & Training, and Web site. In the table of contents, articles are also identified by area of interest, such as drugs, mobility/support surfaces, oxygen etc. Articles that may be of interest to a variety of audiences are identified as general articles. Furthermore, all contact information, i.e., telephone numbers and addresses, is available on the back cover.

We hope these new features enhance the readability of the bulletin, and allow you to easily and quickly find the information you're interested in.

Tips for Online Bulletins

The Region A Durable Medical Equipment Regional Carrier (DMERC A) provides the *DMERC Medicare News* in two formats on our Web site. Both contain the same information, however, they will look different when viewing and printing. One format is Web-based. The second format is Adobe's Portable Document Format (PDF), which maintains the look of printed bulletins.

To properly view PDF bulletins on the DMERC A Web site, it is <u>strongly</u> recommended that you download the PDF to your computer first, then open the PDF with Adobe Acrobat Reader®, rather than opening it within your Web browser.

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If you select the "All" option for your print range, you can save paper by specifying odd or even page printing and print on both sides; thereby, making your printed copy look similar to a printed bulletin. If your printer cannot accommodate duplex printing, you will need to feed the paper through twice; once for the odd pages, and again for the even pages. (Note: Make sure you put the pages in the correct order and face them in the proper direction for printing on the reverse side.)

Another way to save paper is by choosing specific pages to print, when you don't need to read or refer to the entire bulletin. This way, you will have just the pertinent information on hand when it is needed.

While visiting the DMERC A Web site, please take a few moments to complete our Online Newsletter Survey at

www.umd.nycpic.com/dmercbulletinsurvey.html.

Your responses will assist us in meeting your needs and improving our online bulletins.

Billing

Filing the Request for Payment

A claim is a writing, identifying or permitting the identification of an enrollee, which requests payment for what appears to be Part B medical or other health services furnished by a physician or supplier. The Centers for Medicare & Medicaid Services (CMS) instructions for submitting claims to Medicare are contained in Pub. 100-4, Medicare Claims Processing Manual, Chapter 1. In order for a request for payment to be considered to have been filed timely in accordance with CMS instructions, the claim must not be considered to be unprocessable under the definition of an unprocessable claim found in Pub. 100-4, Chapter 1, § 80.3.1.

Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis (including those services for which the charge is related to cost). For these services, the terms of the law require that the claim be filed no later than the end of the calendar year following the year in which the service was furnished, except as follows:

- The time limit on filing claims for service furnished in the last three (3) months of a year is the same as if the services had been furnished in the subsequent year. Thus, the time limit on filing claims for services furnished in the last 3 months of the year is December 31 of the second year following the year in which the services were rendered.

Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, federal non-workday or legal holiday, the claim will be considered filed timely if it is filed on the next workday. (See Pub. 100-4, Chapter 1, § 50.1.8.) The table that follows illustrates the timely filing limit for dates of service in each calendar month.

Table: Usual Time Limit

Date of Service in	Timely Filing Date	Months to File *
Jan	Dec 31: Service year plus 1 year	23
Feb	Dec 31: Service year plus 1 year	22
Mar	Dec 31: Service year plus 1 year	21
Apr	Dec 31: Service year plus 1 year	20
May	Dec 31: Service year plus 1 year	19
June	Dec 31: Service year plus 1 year	18
July	Dec 31: Service year plus 1 year	17
Aug	Dec 31: Service year plus 1 year	16
Sep	Dec 31: Service year plus 1 year	15
Oct	Dec 31: Service year plus 1 year	26
Nov	Dec 31: Service year plus 1 year	25
Dec	Dec 31: Service year plus 1 year	24

* The number specified in "Months to File" represents the number of full months remaining after the month in which the service was rendered.

Section 1848(g)(4) of the Social Security Act requires that physicians and suppliers complete and submit Part B claims for medical services, equipment and supplies (furnished on or after September 1, 1990) within twelve (12) months of the service date. Only assigned claims submitted more than 12 months after the service date will be subject to a 10 percent reduction of the amount that would otherwise have been paid. Payment on an assigned claim submitted by a physician or other supplier 12 months or longer after the service is furnished, shall be reduced by 10 percent from the amount that would have otherwise been paid.

The purpose of a Statement of Intent (SOI) is to extend the timely filing period for the submission of an initial claim. An SOI by itself does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. For more information on SOIs, refer to the article "Written Statements of Intent (SOI) to Claim Medicare Benefits" under "Billing" at ***www.umd.nycpic.com/dmbilltips.html#soi***.

To read the manual update in its entirety, refer to Chapter III in the Medicare Carriers Manual (MCM) at ***www.cms.hhs.gov/manuals/14_car/3b3000.asp***.

[Reference: Change Request (CR) 2815; Transmittal 1818]

Additional Documentation Reminder

Providers should refer to the individual medical policies for specific documentation provisions, particularly in regards to claims submission. The medical policies for Region A are available on the Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/lmrp_current_dyn.cfm***.

A Certificate of Medical Necessity (CMN) is not considered additional documentation. CMNs should be submitted in hardcopy with CMS-1500 forms or via the electronic equivalent. Refer to the individual medical policies for specific documentation provisions regarding CMNs.

The Region A Durable Medical Equipment Regional Carrier (DMERC A) has seen an increase in duplicate submission of additional documentation for items that do not require this information with each claim billed (e.g., wheelchairs). A copy of the original documentation should be submitted, via fax or mail, to DMERC A **one time only**. Submission each month is not necessary and may cause delays in claims processing for these items.

If the available electronic narrative element is unable to accommodate the submission of additional documentation when transmitting an electronic claim, paper documentation may have to be submitted. When submitting additional documentation for claims, the documentation must be received in our office at least 48 hours (two business days) before the claim is transmitted. If DMERC A does not receive the documentation within that timeframe, there is no guarantee that the claim will be matched with the documentation.

The documentation can either be faxed to 570-735-9402 or mailed to DMERC A, P.O. Box 6800, Wilkes-Barre, PA 18773-6800. Providers must indicate in the HA0 record (NSF format) or the NTE 2400 loop (ANSI format) the date the additional documentation was faxed or mailed. If the documentation is mailed, be sure to allow enough time for it to be received at least 48 hours before the claim is transmitted.

A cover sheet **must** be used when sending additional documentation to DMERC A. The cover sheet can be obtained from the "EDI - Documents and Files" section of our Web site (***www.umd.nycpic.com/edidocfiles.html***), or directly at ***www.umd.nycpic.com/extra.html***. Use of this cover sheet will insure proper routing of the documentation and will expedite the processing of your claims. The cover sheet should be used for additional documentation for both electronic and paper (unless it is attached to the original) claims.

DMERC A will **not** accept additional documentation via the Internet.

New Requirements - Physician's Order and CMNs

Under certain circumstances, payment may be made for repair, maintenance, and replacement of medically required durable medical equipment (DME), including equipment which had been in use before the user enrolled in Part B of the Medicare program. To repair means to fix or mend and to put the equipment back in good condition after damage or wear. A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

Routine periodic maintenance, such as testing, cleaning, regulating and checking of the beneficiary's equipment is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a beneficiary owns. A new CMN and/or physician's order is not needed for covered maintenance.

Replacement refers to the provision of an identical or nearly identical item. Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). A physician's order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item. Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified.

Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment. If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, the beneficiary may elect to obtain a new piece of equipment. Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

These changes are **effective January 1, 2004**. For more information, refer to the articles titled "Repairs/Replacement Chart" and "Repairs, Maintenance, Replacement & Delivery" under the September 2003 Bulletins listed on the "What's New" page of the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

[Reference: Change Request (CR) 2751; Transmittal 1815]

Maintenance and Service Billing Reminder and Resolution to Denial

Suppliers must not submit claims for maintenance and servicing until **all** claims for rental have been paid (fifteen months) and six months have passed since the final rental month was paid (see Pub. 100-4, Medicare Claims Processing Manual, Chapter 20). If there is no evidence of a Certificate of Medical Necessity (CMN) on file for those items requiring a CMN, and fifteen months of rental have been paid, the maintenance and service claim will be denied (CO-30). Furthermore, suppliers should not bill for maintenance and servicing codes (MS modifier) on the same claim as codes for the rental itself.

Denials for maintenance and service claims not meeting the required criteria must be submitted as a written review for resolution. **The telephone review process will not handle this type of denial.**

The following information is required to be submitted with the review request.

Capped rental item requiring a CMN

Suppliers should submit a copy of the original CMN, valid for the time period when the original rental occurred, along with the following verbiage with the request:

> "Previous rentals have been billed and allowed or have not been billed, but are now beyond Medicare's timely filing limitation for claim submission. Please review the enclosed CMN that originally qualified this item for coverage and continue payment for MS."

Capped rental item not requiring a CMN

Suppliers should submit a copy of the original physician's order/prescription, valid for the time period when the original rental occurred, along with the following verbiage with the request:

> "Previous rentals have been billed and allowed or have not been billed, but are now beyond Medicare's timely filing limitation for claim submission. Please review the enclosed doctor's order/prescription that originally qualified this item for coverage and continue payment for MS."

Capped rental item for which the original CMN or physician's order/prescription is not available (e.g., acquisition situation, beneficiary from one supplier to another)

Suppliers should submit a copy of the CMN or physician's order/prescription (new/revised) on file with the current supplier, validating the medical necessity of the item for the time period in which the MS is being billed, along with the following verbiage:

> "Due to provider acquisition, previous rentals have been billed and allowed or have not been billed, but are now beyond Medicare's timely filing limitation for claim submission. No record of original qualifying CMN or doctor's order for this item. Please review the enclosed (new or revised) CMN or doctor's order which validates the patient's continued need for this item and continue payment for MS."

Note: The supplier is not required to produce and submit Provider Remittance Notices showing the payment of 15 rental months for the above mentioned denial situations.

2004 HCPCS Annual Update Reminder

Medicare providers submitting claims to Medicare contractors use a Healthcare Common Procedure Coding System (HCPCS) code to indicate the service that was provided. The new 2004 HCPCS update is **effective for dates of service on or after January 1, 2004**. The 3-month grace period applies to claims received prior to April 1, 2004, which contain 2003 discontinued codes, for dates of service January 1, 2004, through March 31, 2004.

For more information on HCPCS, visit the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com***.

[Reference: Change Request (CR) 2896; Transmittal AB-03-140]

Reasonable Charge Update for 2004

Payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes, and intraocular lenses by regulations contained in 42 CFR 405.501. The update for 2004 includes Healthcare Common Procedure Coding System (HCPCS) changes which will become **effective January 1, 2004**.

The following list of "K" codes became effective July 1, 2003, and they are being replaced by the crosswalked new codes. The 3-month grace period applies to the deleted "K" codes.

Old "K" Code	New Crosswalk Code
K0610	E1634
K0611	A4671
K0612	A4672
K0613	A4673
K0614	A4674

In addition, code A4712 is being replaced by the new code/modifier A4216AX. The 3-month grace period applies to A4712.

For more information on HCPCS, visit the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com***.

[Reference: Change Request (CR) 2941; Transmittal 9]

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency. This requirement is found in Medicare regulations at 42 CFR 409.100.

The HH consolidated billing code lists are updated annually to reflect the annual changes to the HCPCS code set itself. Claims with **dates of service on or after January 1, 2004**, shall be subject to the updated list of codes used to enforce HH consolidated billing. Providers and suppliers can access the master list online at ***www.cms.hhs.gov/providers/hhapps/#billing***. The following are the coding changes in the 2004 update.

Code	Action	Replacement Code or Code Being Replaced
Non-Routine Supplies:		
K0581	Delete	Replacement Code: A4416
K0582	Delete	Replacement Code: A4417
K0583	Delete	Replacement Code: A4418
K0584	Delete	Replacement Code: A4419
K0585	Delete	Replacement Code: A4420
K0586	Delete	Replacement Code: A4423
K0587	Delete	Replacement Code: A4424
K0588	Delete	Replacement Code: A4425
K0589	Delete	Replacement Code: A4426
K0590	Delete	Replacement Code: A4427
K0591	Delete	Replacement Code: A4428
K0592	Delete	Replacement Code: A4429
K0593	Delete	Replacement Code: A4430

Code	Action	Replacement Code or Code Being Replaced
K0594	Delete	Replacement Code: A4431
K0595	Delete	Replacement Code: A4432
K0596	Delete	Replacement Code: A4433
K0597	Delete	Replacement Code: A4434
A4416	Add	Replaces Code: K0581
A4417	Add	Replaces Code: K0582
A4418	Add	Replaces Code: K0583
A4419	Add	Replaces Code: K0584
A4420	Add	Replaces Code: K0585
A4423	Add	Replaces Code: K0586
A4424	Add	Replaces Code: K0587
A4425	Add	Replaces Code: K0588
A4426	Add	Replaces Code: K0589
A4427	Add	Replaces Code: K0590
A4428	Add	Replaces Code: K0591
A4429	Add	Replaces Code: K0592
A4430	Add	Replaces Code: K0593
A4431	Add	Replaces Code: K0594
A4432	Add	Replaces Code: K0595
A4433	Add	Replaces Code: K0596
A4434	Add	Replaces Code: K0597
A4319	Delete	Replacement codes: A4216 & A4217
A4323	Delete	Replacement codes: A4216 & A4217
A4216	Add	Replaces A4319 & A4323
A4217	Add	Replaces A4319 & A4323
A4712	Delete	None
A4622	Delete	Replacement codes: A7520, A7521, & A7522
A7520	Add	Replaces code: A4622
A7521	Add	Replaces code: A4622
A7522	Add	Replaces code: A4622
A7523	Add	From or related to discontinued code, A4622 and/or A4623: Tracheostomy
A7524	Add	From or related to discontinued code, A4622 and/or A4623: Tracheostomy
A4623	Add	None
A7525	Add	Replaces code: A4623
A7526	Add	Replaces code: A4623
K0621	Delete	Replacement code: A6407
A6407	Add	Replaces: K0621
A4248	Add	None
A4366	Add	None
A6025	Add	None
A6441	Add	None
A6442	Add	None
A6443	Add	None
A6444	Add	None
A6445	Add	None
A6446	Add	None
A6447	Add	None
A6448	Add	None
A6449	Add	None
A6450	Add	None
A6451	Add	None
A6452	Add	None
A6453	Add	None
A6454	Add	None
A6455	Add	None
A6456	Add	None
Therapies:		
97755	Add	None

[Reference: Change Request (CR) 2931; Transmittal 8]

2004 Annual Update for Skilled Nursing Facility Consolidated Billing

The coding files for skilled nursing facility consolidated billing will be updated effective January 1, 2004. These updates will appear on the Centers for Medicare & Medicaid Services' (CMS') Web site at ***www.cms.hhs.gov/medlearn/snfcodes.asp*** on or about December 1, 2003. In order to correctly bill services, physicians, non-physician practitioners, and suppliers should carefully review the revised codes files.

[Reference: Change Request (CR) 2858; Transmittal B-03-068]

From the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network:

Guidelines for Skilled Nursing Facility Consolidated Billing

This provider education article discusses the background of the Skilled Nursing Facility (SNF) consolidated billing regulation; services, supplies, and facilities included and excluded from SNF consolidated billing; professional and technical components of diagnostic tests; and ambulance services. In addition, the article includes information resources for SNF consolidated billing.

Background

Skilled Nursing Facility (SNF) consolidated billing, which was effective for cost reporting periods beginning on or after July 1, 1998, states that SNFs must submit Medicare claims to the fiscal intermediary (FI) for all Part A and Part B services that its residents receive during the course of a covered Part A stay, except for a limited number of specifically excluded services. These services must be furnished either directly or under arrangement with outside providers. Section 4432(b) of the Balanced Budget Act of 1997 (BBA, PL 105-33), mandated the exclusion of entire categories of services from SNF consolidated billing. These services are separately billable to the Part B Medicare carrier and include the services of physicians and certain other types of medical practitioners.

Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA, PL 106-113, Appendix F), effective on April 1, 2000, enacted a second more targeted set of exclusions for high cost, low probability services within a number of broader service categories (e.g., chemotherapy services) that otherwise remained subject to consolidated billing.

Effective January 1, 2002, Section 313 of the Benefits Improvement and Protection Act restricted SNF consolidated billing to the majority of services provided to patients in a Medicare Part A covered stay and only to physical, occupational, and speech-language therapy services provided to patients in a noncovered stay.

For claims with dates of service on or after April 1, 2001, for those services and supplies that are not specifically excluded by law and furnished to a SNF resident covered under the Part A benefit, physicians must forward the technical portions of any services to the SNF to be billed by the SNF to the FI. The SNF cannot receive additional payment for these technical services and is to pay the physician for the technical portion of the service. Physical, occupational, and speech-language therapy services provided to patients in a noncovered stay must also be forwarded to the SNF to be billed by the SNF to the FI for payment. It is the responsibility of the rendering physician or non-physician practitioner to develop a business relationship with the SNF in order to receive payment from the SNF for services they render that are included in consolidated billing.

Services and Supplies Included in SNF Consolidated Billing

The SNF consolidated billing requirement confers on SNFs the billing responsibility for the entire package of services that residents receive including:

- All services and supplies received during the course of a Part A covered stay (including physical, occupational, and speech-language therapy services), with the exception of statutory exclusions; and

- For SNF residents in noncovered stays (e.g., Part A benefits exhausted or no prior qualifying hospital stay), physical, occupational, and speech-language therapy services.

Services and Supplies Excluded from SNF Consolidated Billing

A. The following are excluded from SNF consolidated billing and must be billed separately to the Medicare carrier:

- The professional component of physician services (see Section 1861(r) of the Social Security Act for the definition of a physician for Medicare purposes) except physical, occupational, and speech-language therapy services;

- Physician assistant services, when a physician assistant is working under a physician's supervision;
- Nurse practitioner services, when a nurse practitioner is working in collaboration with a physician;
- Clinical nurse specialists, when a clinical nurse specialist is working in collaboration with a physician;
- Certified mid-wife services;
- Qualified psychologist services; and
- Certified registered nurse anesthetist services.

NOTE: Physical, occupational, and speech-language therapy services included in SNF consolidated billing are subject to SNF consolidated billing regardless of who provides them, even if the services that type of practitioner normally provides are excluded from SNF consolidated billing.

B. The following are excluded from SNF consolidated billing and the institutional or technical component must be billed separately to the Medicare FI:

- The following services furnished on an outpatient basis by a hospital or critical access hospital (CAH):
  - Cardiac catheterization services;
  - Computerized axial tomography scans;
  - Magnetic resonance imaging;
  - Ambulatory surgery involving the use of an operating room;
  - Radiation therapy;
  - Emergency services;
  - Angiography;
  - Lymphatic and venous procedures; and
  - Ambulance services furnished in connection with any of the above outpatient hospital services.
- Maintenance dialysis received in a Renal Dialysis Facility by an End Stage Renal Disease patient;
- Certain dialysis-related services including covered ambulance transportation to obtain dialysis services;
- Erythropoietin for certain dialysis patients when given along with dialysis; and
- Hospice care related to a patient's terminal condition.

C. The following are excluded from SNF consolidated billing and must be billed separately to the Medicare carrier or FI, as appropriate:

- Ambulance trips that transport a patient to the SNF for initial admission or from the SNF following a final discharge (see below for additional ambulance services information);
- Services to risk based health maintenance organization (HMO) enrollees; and
- The following services for residents in a Part A covered stay (only certain services in these categories are excluded):
  - Certain chemotherapy drugs;
  - Certain chemotherapy administrative services;
  - Certain radioisotope services; and
  - Certain customized prosthetic devices.

Facilities Included in SNF Consolidated Billing

- Medicare participating SNFs, including Medicare-certified distinct part SNFs and swing beds in all hospitals except CAHs.

Facilities Excluded from SNF Consolidated Billing

- Nursing homes that have no Medicare certification (e.g., do not participate at all in either the Medicare or Medicaid program);
- Nursing homes that exclusively participate only in the Medicaid program as a nursing facility;
- The non-participating portion of a nursing home that also contains a Medicare-certified distinct part SNF; and
- Swing beds in CAHs.

Professional and Technical Components of Diagnostic Tests

The professional component, or the physician's interpretation of a diagnostic test, is considered a physician service and is separately billable to the Medicare carrier. The technical component, or the diagnostic test itself, is considered a diagnostic test and is subject to consolidated billing. As an example, for diagnostic radiology services, the exclusion of physician services from consolidated billing applies only to the professional component of the diagnostic radiology service. The technical component of the diagnostic radiology service is considered a diagnostic test that must be billed to the Medicare FI by the SNF and is included in the SNF consolidated billing payment for covered Part A stays. Because the technical component is already included within Part A's comprehensive per diem payment to the SNF for the covered stay, an outside entity that actually furnishes the technical component would look to the SNF, rather than Part B, for payment.

Ambulance Services

Except for specific exclusions, SNF consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a Part A stay. In most cases, ambulance trips are excluded from SNF consolidated billing when the covered Part A stay has ended, at which time the ambulance company must bill the Medicare carrier or FI directly for payment. The specific circumstances under which a patient may receive ambulance services that are covered by Medicare but excluded from SNF consolidated billing are:

- A medically necessary ambulance trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded outpatient hospital services;
- A medically necessary ambulance trip after a formal discharge or other departure from the SNF, unless the patient is readmitted or returns to that or another SNF before midnight of the same day;
- An ambulance trip to receive dialysis or dialysis-related services;
- An ambulance trip for an inpatient admission to a Medicare participating hospital or CAH; and
- After discharge from a SNF, a medically necessary ambulance trip to the patient's home where he/she will receive services from a Medicare participating home health agency under a plan of care.

NOTE: A patient's transfer from one SNF to another before midnight of the same day is not excluded from SNF consolidated billing. The first SNF is responsible for the ambulance services.

SNF Consolidated Billing Information Resources

- Consolidated Billing Web site

  www.cms.hhs.gov/medlearn/snfcode.asp

  - General SNF consolidated billing information
  - Healthcare Common Procedure Coding System (HCPCS) codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing)
  - Therapy codes that must be consolidated in a noncovered stay
  - All code lists are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions

- Program Memorandums

  www.cms.hhs.gov/manuals/tranmittals/comm_date_dsc.asp

  - Transmittal AB-03-094, dated July 3, 2003
  - Transmittal AB-02-175, dated December 13, 2002
  - Transmittal A-02-118, dated November 8, 2002
    1) Updated codes for exclusions
    2) SNF Help File

a) HCPCS codes included in the SNF Part A payment
b) Codes that may be paid and on what basis to a SNF by the FI under Part B

- Transmittal AB-02-038, dated March 27, 2002

- The SNF Help File will be available on a new CMS Web site in the near future.

- Medicare Carriers Manual Part 3, Section 4210.

Billing Guidelines for Outpatient Rehabilitation Services

This provider education article discusses the background of the outpatient rehabilitation services limitation regulation, therapy modifiers, applicable outpatient rehabilitation Healthcare Common Procedure Coding System (HCPCS) and revenue codes, and billing instructions. In addition, it includes information resources for outpatient rehabilitation services.

Background

Section 4541(a)(2) of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33) required payment under a prospective payment system for outpatient rehabilitation services, which includes the following services:

- Physical therapy, including outpatient speech-language pathology; and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services. These limits do not apply to therapy rendered by outpatient departments of hospitals unless the beneficiary is a resident of either a Medicare-certified skilled nursing facility or a Medicare-certified portion of a skilled nursing facility. These limits were applied in 1999. However, due to a Congressionally-imposed moratorium, the limits have not been effective during the years 2000, 2001, or 2002. The outpatient rehabilitation services financial limitations were initially planned to resume on July 1, 2003, but their implementation has been delayed. The limitations on outpatient rehabilitation therapy services have been implemented again on September 1, 2003.

Therapy Modifiers

For any applicable rehabilitation therapy service that is rendered, providers/suppliers must report one of the following therapy modifiers, which were effective on January 1, 2003:

GN Services delivered under an outpatient speech-language pathology plan of care.

GO Services delivered under an outpatient occupational therapy plan of care.

GP Services delivered under an outpatient physical therapy plan of care.

Note: These therapy modifiers do not allow a provider to deliver services that they are not recognized by Medicare to perform.

Applicable Outpatient Rehabilitation HCPCS and Revenue Codes

- The HCPCS code list for outpatient rehabilitation services was revised in Transmittal B-03-065 to include additional codes that will not apply to the financial limitations when billed by physicians and non-physician practitioners, as appropriate.

- These codes supersede the codes listed in §3653 of the Medicare Part A Intermediary Manual, Part 3.

- This listing of HCPCS codes does not imply that services are covered.

- HCPCS apply to each financial limitation except as noted below.

29065+	29075+	29085+	29086+
29105+	29125+	29126+	29130+
29131+	29200+	29220+	29240+
29260+	29280+	29345+	29355+
29365+	29405+	29425+	29445+
29505+	29515+	29520+	29530+
29540+	29550+	29580+	29590+

64550+	90901+	90911+	92506
92507	92508	92526	92597
92601++	92602++	92603++	92604++
92607	92608	92609	92610+
92611+	92612+	92614+	92616+
95831+	95832+	95833+	95834+
95851+	95852+	96000+	96001+
96002+	96003+	96105+	96110+*
96111+	96115+	97001	97002
97003	97004	97012	97016
97018	97020	97022	97024
97026	97028	97032	97033
97034	97035	97036	97039
97110	97112	97113	97116
97124	97139	97140	97150
97504**	97520	97530	97532
97533	97535	97537	97542
97601+	97703	97750	97799*
V5362*	V5363*	V5364*	G0279+***
G0280+***	G0281	G0283	0020T+***
0029T+***			

\+ The physician fee schedule abstract file does not contain a price for codes **96110, 97799, V5362, V5363,** and **V5364** since they are priced by the carrier. Therefore, contact the carrier to obtain the appropriate fee schedule amount in order to make proper payment for these codes.

** Code **97504** should not be reported with code **97116**. However, if code **97504** was performed on an upper extremity and code **97116** (gait training) was also performed, both codes may be billed with modifier **59** to denote a separate anatomic site.

*** The physician fee schedule abstract file does not contain a price for codes **G0279, G0280, 0020T, 0029T** since they are priced by the carrier. In addition, coverage for these codes is determined by the carrier. Therefore, contact the carrier to obtain the appropriate fee schedule amount.

\+ These codes will not apply to the financial limits when they are not done under a therapy plan of care and they are billed by providers of services who are represented by any specialty codes except 65 and 67 (PT in Private Practice, OT in Private Practice), also 73 and 74 (which were incorrectly noted in AB-03-018 and have since been reassigned to specialties that are not therapy services.) Specialty codes 73 and 74 will be removed in a future instruction. Physicians and non-physician practitioners should only use therapy modifiers (**GP, GN, GO**) with the above codes when the services are provided under a therapy plan of care.

++ If an audiology procedure (HCPCS) code is performed by an audiologist, the above modifiers should not be reported, as these procedures are not subject to the financial limitation. When these HCPCS codes are billed under a speech-language pathology plan of care, they should be accompanied with a **GN** modifier and applied to the financial limitation.

Billing Instructions

- Claims must include PT, OT, or SLP modifiers (**GP, GO,** and **GN**) when any of the HCPCS codes listed above are used (see exceptions noted by + and ++ in the footnote following the list above). Claims will be returned to providers/suppliers and processing will be delayed if the modifiers are not included.

- In addition, it has been noted that some providers are using modifiers inappropriately with HCPCS codes that are not on the above list. As a result, charges will be incorrectly applied to therapy caps.

- Providers should be aware that billing a modifier inappropriately with HCPCS or revenue codes that are not listed above may result in charges incorrectly applied to whichever therapy cap the modifier denotes. This incorrect billing deprives the recipient of benefits to which they are entitled and which are not subject to the financial limitation.

- The HCPCS codes marked + on the list above may or may not be considered outpatient rehabilitation services, depending on the circumstances and the practitioners involved. These codes always represent therapy services when done by therapists. They also represent rehabilitation therapy services when done by physicians and non-physician practitioners who are licensed to provide therapy services and the services are not isolated medical services (e.g., a cast) but part of an episode of care whose goal is rehabilitation. When outpatient rehabilitation therapy services are billed, therapy modifiers must be used and all requirements for rehabilitation therapy services must be followed, including a plan of care.

- Diagnostic audiology codes do not require therapy modifiers (see audiology procedure footnote ++ in above list). Audiology services are not subject to therapy caps. Speech-language pathologists are not qualified to perform diagnostic audiology services. The audiology codes will be removed from the list in a future instruction.

- Contact your local Part B carrier for more information.

Outpatient Rehabilitation Services Information Resources

Program Memorandums - available on the Centers for Medicare & Medicaid Services (CMS) Web site at ***www.cms.hhs.gov/manuals/memos/comm_date_dsc.asp***.

- Transmittal B-03-065, dated August 22, 2003
- Transmittal B-03-051, dated July 16, 2003
- Transmittal AB-03-097, dated July 3, 2003
- Transmittal AB-03-085, dated June 10, 2003
- Transmittal AB-03-073, dated May 23, 2003
- Transmittal AB-03-057, dated May 2, 2003
- Transmittal AB-03-018, dated February 7, 2003

Therapy Resources Web Site - ***www.cms.hhs.gov/medlearn/therapy***.

- Medicare therapy news
- Frequently asked questions
- General information documents
- Therapy medical review operations
- General research tools for therapy topics
- Research tools for specific therapy topics
- Evidence-based literature review
- Join therapy cap ListServe (electronic mailing list)

Update to Outpatient Therapy

Section 4541(a)(2) of the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), which added §1834(k)(5) to the Social Security Act (the Act), required payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical therapy (which includes outpatient speech-language pathology); and
- Occupational therapy.

Section 4541(c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital) of an annual per beneficiary limit of $1500 for all outpatient physical therapy services (including speech-language pathology services), and a separate $1500 limit for all occupational therapy services. The $1500 limit is based on incurred expenses and includes applicable deductible ($100) and co-insurance (20 percent). The annual limitation does not apply to services furnished directly or under arrangement by a hospital to an outpatient, or to a hospital inpatient who is not in a covered Part A stay. The BBA provided that the $1500 limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

For the calendar year 2004, the limit for outpatient physical therapy and speech-language pathology combined is $1640; the limit for occupational therapy is $1640. These limits apply to **dates of service between January 1, 2004, and December 31, 2004**.

Providers/suppliers may use the Notice of Exclusions from Medicare Benefits (NEMB; Form No. CMS-20007) or a similar form of their own design to notify beneficiaries of the therapy financial limitations and that these limits are applied in all settings except hospital outpatient departments. Advance Beneficiary Notices (ABNs) **cannot** be used because of the statutory nature of the financial limitations. Therefore, providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy limit, unless this outpatient care is furnished directly or under arrangement by a hospital.

It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits and that, where necessary, appropriate care above the limit can be obtained at a hospital outpatient therapy department. Providers/suppliers use the NEMB form to inform beneficiaries of the therapy financial limitation at their first therapy encounter with the beneficiary. When using the NEMB form, the

practitioner checks box number 1 and writes the reason for denial in the space provided at the top of the form. Provide the following reason: "Medicare will not pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap and the year or the dates of service to which it applies)." This same information is provided for occupational therapy services over the limit for the same time period, as appropriate.

The NEMB form can be found on the Centers for Medicare & Medicaid Services (CMS) Web site at ***www.cms.hhs.gov/medlearn/refabn.asp***.

[Reference: Change Request (CR) 2973; Transmittal 30]

Individuals Not Subject to the Limitation on Payment

Pub. 100-5, Medicare Secondary Payer Manual, Chapter 2, §10.2 has been revised as follows to add the last bullet, which is **effective April 1, 2004**.

The Medicare secondary (MSP) provision for working aged does not apply to:

- Individuals enrolled in Part B only;
- Individuals enrolled in Part A on the basis of a monthly premium. Anyone who is under age 65. (Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.);
- Individuals covered by a health plan other than an GHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group, and for which payment is not made through an employer;
- Employees of employers of fewer than 20 employees who are covered by a single employer plan. Members of multi-employer plans, which have been approved by CMS for the "multi-employer exemption," whom the plan identified as employees of employers with fewer than 20 employees;
- Retired beneficiaries who are covered by GHPs as a result of past employment and who do not have GHP coverage as the result of their own or a spouse's current employment status;
- Individuals enrolled in single employer GHPs of employers of fewer than 20 employees; or
- Members of multi-employer plans whom the plan identified as employees of employers with fewer than 20 employees, provided the plan formally elected (see §10.4) to exempt the plan from making primary payment for employees and spouses of employees of specifically identified employers with fewer than 20 employees.
- Domestic partners who are given "spousal" coverage by the group health plan. Federal law defines spouse as a person of the opposite sex who is a husband or a wife. Thus a domestic partner cannot be recognized as a spouse.

[Reference: Change Request (CR) 2252; Transmittal 2]

Consolidation of Claims Crossover Process

The Centers for Medicare & Medicaid Services (CMS) has decided to streamline the claims crossover process to better serve our customers. Medicare complementary insurers (i.e., non-Medigap plans), Title XIX State Medicaid Agencies, and Medigap plans - collectively known as coordination of benefit (COB) trading partners - that are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability will no longer have to sign separate agreements with individual Medicare contractors. Each COB trading partner will enter into one national Coordination of Benefits Agreement (COBA) with CMS' consolidated claims crossover contractor, the Coordination of Benefits Contractor (COBC). Likewise, each COB trading partner will no longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers, or receive numerous crossover files. The COBC shall be designated to collect crossover fees from all COB trading partners (except for Title XIX State Medicaid Agencies which are exempt from such fees) on behalf of CMS. CMS will begin to convert private insurers to the COBC in April 2004.

Further information, including who providers should contact for specific types of COB questions once insurers are converted to COBC processing, will be covered in a future publication.

[References: Change Request (CR) 2961, Transmittal 29; CR 2962, Transmittal 28]

EDI & HIPAA

Are You Submitting HIPAA-Compliant Electronic Transactions?

The Region A Durable Medical Equipment Regional Carrier (DMERC A) is now receiving about 75% of our accepted inbound electronic claims volume in ANSI 837 format, and all new electronic submitters must use the HIPAA-compliant transactions for sending claims (ANSI 837 or NCPDP) and for receiving an electronic remittance advice (ANSI 835). Get current information on HIPAA requirements and DMERC implementation instructions on the DMERC A Web site at ***www.umd.nycpic.com/emc&hipaa.html.***

CMS Contingency Plan

Due to the large number of providers who were not HIPAA-compliant by October 16, 2003, the Centers for Medicare & Medicaid Services (CMS) invoked a contingency plan to continue accepting electronic claims in the pre-HIPAA (NSF) format for some limited period of time. The contingency plan **does not** delay the CMS mandate to eliminate paper billing for all but a very few exceptions; it just allows existing electronic submitters to keep using the older format while they make "good faith" efforts to complete their transition to the HIPAA transactions.

Vendor Testing

If your HIPAA-compliant software vendor has passed testing with one of the four regional DMERCs, and you are currently submitting electronic claims to DMERC A, you are not required to conduct your own testing, but you may do so if you wish. If you are not currently submitting electronic claims to DMERC A, you must successfully complete testing. Refer to our Web site, as noted above, or call the EDI Help Desk toll-free at 866-861-7348.

Electronic Billing Information

The Region A Durable Medical Equipment Regional Carrier (DMERC A) posted new and updated electronic billing information to our Web site. An upgrade was made to the HIPAA-compliant software, ExpressPlus. To access this upgrade:

- Visit ***www.umd.nycpic.com/edisoftware.html***
- Click on "Upgrades"
- Follow the instructions for "Narrative Field Size Fix"

In addition, the following information is available at ***www.umd.nycpic.com/edidocfiles.html*** (under Files):

- ANSI Error Code Manual
  (This is an Adobe® Portable Document Format (PDF) file.)
- ANSI Vendor Listing
- Suggested Abbreviations When Reporting Additional Documentation Notations in the ANSI and NCPDP Formats

Update to Health Care Claims Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers must use health care claims status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee. At each X12 trimester meeting (generally held in the months of February,

June, and October), the Committee may update the claims status category codes and health care claim status codes. The code changes are then subsequently posted to the Washington Publishing Company (WPC) Web site at ***www.wpc-edi.com/codes/Codes.asp***. Beginning September 1, 2003, providers/submitters may see all applicable code changes and new codes, which were posted to the WPC Web site with the "new as of February 2003" designation and prior dates, in 277 responses.

For the list of codes used by the Region A Durable Medical Equipment Regional Carrier (DMERC A), refer to the article on page 12 in the June 2003 *DMERC Medicare News*.

[Reference: Change Request (CR) 2786; Transmittal AB-03-131]

X12N 276/277 Companion Document

The Companion Document for Accredited Standards Committee (ASC) X12N 276/277 Health Care Claim Status Request and Response (version 4010A1) is available on the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site. To access this important information, visit the "EDI & HIPAA" section (***www.umd.nycpic.com/emc&hipaa.html***) of the DMERC A Web site, then click on "X12N 276/277 Companion Document" under Articles.

[Reference: Change Request (CR) 2742; Transmittal AB-03-141]

Miscellaneous

New Call Center Hours

Effective October 1, 2003, DMERC A's call center hours changed to **8:00 a.m. - 4:30 p.m**. This change affects 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.

Update to DMERC A P.O. Boxes

In December 2002, the Region A Durable Medical Equipment Regional Carrier (DMERC A) implemented additional post office (P.O.) boxes to enhance customer service, save time on processing, and expedite payment. A listing has been published on the back cover of the quarterly bulletins since that time. This listing has been updated to include the direct zip codes to ensure incoming mail is handled efficiently. Please refer to this listing when mailing claims and other correspondence to DMERC A.

DMERC A's Gift Policy

During the holiday season, people often like to show their appreciation with gifts. Occasionally, we at the Region A Durable Medical Equipment Regional Carrier (DMERC A) receive gifts such as candy, fruit baskets, and flowers from beneficiaries, providers, and their billing staffs, in appreciation and thanks for our customer service. While we greatly appreciate the generosity of such gifts, we are unable to accept them. As part of our Code of Conduct, DMERC A has a zero tolerance policy regarding gifts - we cannot accept any.

If you would like to express your thanks for service you have received from DMERC A's representatives, we welcome notes or letters of appreciation in place of gifts.

DMERC A 2004 Holiday Schedule

The Region A Durable Medical Equipment Regional Carrier (DMERC A) will be observing the following holidays:

New Year's Day	Thursday, January 1, 2004
Martin Luther King, Jr. Day	Monday, January 19, 2004
Memorial Day	Monday, May 31, 2004
Independence Day	Monday, July 5, 2004
Labor Day	Monday, September 6, 2004
Thanksgiving Day	Thursday, November 25, 2004
Day after Thanksgiving	Friday, November 26, 2004
Day before Christmas Holiday	Thursday, December 23, 2004
Christmas Holiday	Friday, December 24, 2004

2004 Medicare Deductible, Coinsurance, and Premium Amounts

The following are the Medicare Part A and Part B deductible, coinsurance, and premium amounts for calendar year 2004.

Part A Deductible, Coinsurance, & Premium Amounts

Deductible: $876.00 per benefit period

Coinsurance: $219.00 a day for days 61-90 in each period

$438.00 a day for days 91-150 for each "Lifetime Reserve" day used

$109.50 a day in a Skilled Nursing Facility for days 21-100 in each benefit period

Premium: $343.00 per month for those who must pay a premium

$377.30 per month for those who must pay both a premium and a 10 percent increase

$189.00 per month for those who have 30-39 quarters of coverage

$207.90 per month for those who have 30-39 quarters of coverage and must pay a 10 percent increase

Part B Deductible, Coinsurance, & Premium Amounts

Deductible: $100.00 per year

Coinsurance: 20 percent

Premium: $66.60 per month

[Reference: Change Request (CR) 2969; Transmittal 21]

Program Education & Training

Claim Submission Errors for the Fourth Quarter of Fiscal Year 2003

Claim submission errors (CSEs) are errors made on a claim that would cause it to reject upon submission to the Region A Durable Medical Equipment Regional Carrier (DMERC A). The top ten CSEs for the fourth quarter of fiscal year 2003, which ran from July 1, 2003, to September 30, 2003, are provided in the following chart. During this time frame, there were **23,325** errors on claims submitted electronically, in the National Standard Format (NSF), to DMERC A.

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim.

Claim Submission Error	Correction Electronic	Correction Paper	Total Errors
1) and 2) *Invalid Payor Org ID.* This is used for a secondary insurance crossover. The Other Carrier's Name and Address (OCNA) number can be found on the DMERC A Web site at ***www.umd.nycpic.com/OCNA_01-03.html***.	Enter the nine-digit OCNA number in the DA0-7 and DA0-8 records.	Enter the nine-digit OCNA number in Items 9 and 11.	8,259
3) *Insured's ID number is invalid.* This information is required, whether Medicare is the primary or secondary insurer.	Enter the patient's Medicare Health Insurance Claim (HIC) number in the DA0-18 record.	Enter the patient's Medicare HIC number in Item 1A.	4,382
4) *Ordering/referring physician's Unique Physician Identification Number (UPIN) is missing.* Contact the physician, or obtain a copy of all UPINs from the local Part B Medicare offices or via the	Enter the physician UPIN number in the FB1-9 record.	Enter the physician UPIN number in Item 17A.	2,881

Claim Submission Error	Correction Electronic	Correction Paper	Total Errors
DMERC A Web site at ***www.umd.nycpic.com /dmprovinfo.html*** (UPIN Directory link).			
5) and 6) *Beneficiary's address and zip code are invalid.* This information is required, whether Medicare is the primary or secondary insurer.	Enter the patient's street address on the first line, and the suite or the apartment, room, or floor on the second line (it must have an embedded space; e.g., APT_4) in the CA0-12, Line 2, record, and enter the correct zip code in the FB10701 field	Enter the patient's complete street address, including the correct zip code, in Item 5.	2,265
7) *Invalid Insurance Type Code.* Physicians and suppliers must enter the required information, if requested by the beneficiary.	Enter the insurance type in the DA0-6 record.	Enter the appropriate insurance information in Items 9 and 11.	1,569
8) *Electronic Data Interchange (EDI) enrollment form is invalid.* The EDI Department does not have a valid EDI enrollment form on file for the NSC/ provider number used for billing.	Before billing electronic claims, make sure an enrollment form has been submitted to the EDI Department.	Not applicable. (This pertains to electronic claims only.)	1,538
9) *Invalid diagnosis pointer.* This field cannot be blank (e.g., 1, 2, 3, or 4).	Enter the diagnosis code reference number in the FA0-14 record.	Enter the diagnosis code reference number in Item 24E.	1,484
10) *Invalid service "from" date.* The date of service year must be included.	Enter either a 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date for each procedure, service, or supply in the FA0-5 record.	Enter either a 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date for each procedure, service, or supply in Item 24A.	947

2003 Educational Seminars in Retrospect

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department completed two very successful rounds of seminars during fiscal year 2003. A total of 54 seminars were conducted throughout our ten-state region, reaching approximately 2,000 providers within our service area. Topics included DMERC 101 (Basic Billing), Documentation/Certificates of Medical Necessity (CMNs), Medicare Program Billing Updates, Wheelchair, Vision, and Pharmacy Billing, and Health Insurance Portability and Accountability Act (HIPAA).

Attendees registered via our online registration process, and materials for the seminars were provided in advance via the "Events" section of the DMERC A Web site. These materials have been archived and can be retrieved from the "Education - Seminar Materials" section at ***www.umd.nycpic.com/dmeduc_seminars.html***.

Seminar attendees are asked to complete an evaluation form at the end of each educational session. Among other things, the form asks participants to respond to their overall satisfaction. The overall satisfaction rate for the 2003 seminars was 95% for Met/Exceeded expectations. Participant comments included:

- *"Great overview presentation of the DMERC."*
- *"Very informative."*
- *"I've been a supplier for many years, this was a great review and update."*
- *"Presenters were very knowledgeable, pleasant, and patient."*
- *"Kudos to the wonderful presenters who were professional and helpful."*
- *"Great, cleared up a lot of my confusion. Thanks!"*

Additionally, the evaluations are compiled into comprehensive data packages, which are reviewed for opportunities for improvement with future seminars and for areas where training may be needed to strengthen the skills of the PET Ombudsmen staff. The entire PET staff would like to thank all of the attendees for their enthusiastic participation, and we look forward to seeing you in 2004!

Educational seminars are only one of the avenues used by PET for the dissemination of information about the Medicare program. In 2003, we also participated in numerous state and national outreach events, giving us the opportunity to partner with colleagues and reach a broader spectrum of the provider community.

Providers should check the "Events" section of our Web site (***www.umd.nycpic.com/dmprovcaln.html***) for announcements and schedules of upcoming seminars and outreach events, including our new Web seminars, for 2004.

DMERCs Attend Medtrade Show

Staff from the Region A Durable Medical Equipment Carrier (DMERC A) Program Education & Training (PET) Department attended the **Medtrade** show, held October 9-11, 2003, in Atlanta, GA. All four DMERCs and the National Supplier Clearinghouse (NSC), once again, shared exhibit space. This joint effort gave providers an opportunity to interact with all of the DMERCs and the NSC in one location.

DMERC A provided access to our Web site and assisted providers in the navigation of the DMERC A site, the Region A Program Safeguard Contractor (TriCenturion, LLC) Web site, and various Centers for Medicare & Medicaid Services (CMS) Web sites. Providers expressed satisfaction with the demonstration and found it to be an extremely helpful and informative hands-on experience.

DMERC A also participated in the "DMERC Issues Update" educational session, along with representatives from the other DMERCs. Each representative gave an update on their respective activities and initiatives and provided updates on some of the "hot topics" within the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) industry.

Our experience at this year's show was a positive one. Providers, vendors, and other healthcare professionals were pleased with the DMERCs' attendance and appreciative of the one-on-one interaction and information they received at the event.

PET recognizes these events as an ideal opportunity to offer continued availability to the DMEPOS community. Therefore, we look forward to seeing you at the next **Medtrade**.

Visit the "Events" section of our Web site (***www.umd.nycpic.com/dmprovcaln.html***) to view a picture from the show.

Web site

DMERC A ListServe

The Region A Durable Medical Equipment Regional Carrier (DMERC A) ListServe is used to notify subscribers **via email** of important and time-sensitive Medicare program information, upcoming provider education and training events, and other important announcements or messages. Subscribers will also receive notice of the availability of the quarterly *DMERC Medicare News* on our Web site.

The ListServe is a no-charge feature on the DMERC A Web site. To receive reminders and announcements **via email**, you can subscribe to the DMERC A ListServe by visiting ***www.umd.nycpic.com/dmlistserve.html***. To subscribe, type your email address in the box provided, then click the "Submit" button.

Subscribers can unsubscribe from the DMERC A ListServe anytime. Just type your email address in the box provided, and click the "Submit" button. This will delete you from the ListServe email list.

Reminder: If you change your email address, and you are subscribed to the DMERC A ListServe, you will need to update your information by doing the following:

- Visit ***www.umd.nycpic.com/dmlistserve.html***
- Follow the directions to Unsubscribe
- Subscribe with your new email address

These steps will need to be followed each time you change your email address. If you do not, you will not receive email notification when updates are made to the DMERC A Web site.

Supplier Manual ListServe

With the electronic publication of supplier manual revisions, DMERC A has established a Supplier Manual ListServe to notify subscribers **via email** of the availability of the revised pages. You can subscribe to this new ListServe by doing the following:

- Visit ***www.umd.nycpic.com/dmlistserve.html***
- Go to the Supplier Manual ListServe section
- Follow the directions to Subscribe

Supplier Manual News

The new edition of the Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier manual was posted to our Web site (***www.umd.nycpic.com/suppmancopy.html***) on September 30, 2003. The new edition will **only** be available to current suppliers via our Web site, and newly-enrolled suppliers will continue to receive initial hardcopy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). **The option to request additional copies for a fee is not available to anyone at this time.**

Corrections/updates have been made to Chapter 1 (Contact Information), which was posted to our Web site on October 28, 2003. Revision 2003-01 (October 2003) contains the following changes:

- Call center hours updated to reflect the new hours of operation (see related article)
- Telephone Review Line number corrected to 866-420-6906
- Other DMERC Offices updated to reflect current information (especially Region B)

Corrections/updates have been made to the Table of Contents, Chapter 1 (Contact Information), Chapter 3 (Health Insurance Claim Form), Chapter 4 (Electronic Data Interchange), Chapter 9 (Durable Medical Equipment), and Chapter 10 (Program Safeguard Contractor), which will be posted to our Web site by December 31, 2003. Revision 2003-02 (December 2003) contains the following changes:

- Centers for Medicare & Medicaid Services (CMS) manual references updated to reflect their new online manual system references (see related article)
- DMERC A mailing addresses updated to reflect direct zip codes for P.O. boxes (see related article)
- Electronic Data Interchange (EDI) Help Desk telephone number updated to reflect the new toll-free number: 866-861-7348

Suppliers who maintain hardcopy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. **Please follow the download instructions to print the revised pages.**

Fourth Quarter 2003 Fee Updates

The Region A Durable Medical Equipment Regional Carrier (DMERC A) posts new and updated fees to the "Fee Schedules" section of our Web site at ***www.umd.nycpic.com/dmfees.html***. The following fees have been posted for the fourth quarter 2003:

- 4th Quarter 2003 Update: Drug Fees
- 4th Quarter 2003 Update: Oral Anticancer Drug Fees
- Correction to October Quarterly Update for 2003 DMEPOS Fee Schedule

Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Suppliers without Internet access can request hardcopy versions by writing to:

Attention: FOIA
HealthNow New York Inc. - DMERC A
P.O. Box 1363
Wilkes-Barre, PA 18703-1363

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by sections 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102. Claims for items furnished on or after

January 1, 2004, will be paid in accordance with the amounts for calendar year 2004. Information regarding the 2004 fee schedule amounts will be posted to our Web site prior to their implementation.

[References: Change Request (CR) 2802, Transmittal AB-03-100; CR 2957, Transmittal 17]

Region A Provider Information

Both the Region A Durable Medical Equipment Regional Carrier (DMERC A) and Program Safeguard Contractor (PSC), TriCenturion, LLC, maintain separate Web sites. Providers should visit the DMERC A Web site (***www.umd.nycpic.com***) for information regarding billing, educational updates and events, electronic data interchange (EDI), fee schedules, what's new, etc. Online versions of the *DMERC Medicare News* are also available via this Web site.

Providers can gain access to the PSC Web site via the TriCenturion, LLC link on the DMERC A Web site (***www.umd.nycpic.com/dmprovlink.html***) or directly at ***www.tricenturion.com***. Providers should access the PSC Web site for information on Fraud and Abuse, Healthcare Common Procedure Coding System (HCPCS), and Local Medical Review Policies (LMRPs). Recent updates involving medical policy development, medical review, or benefit integrity are under the PSC "What's New" section at ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

Providers can obtain additional information by visiting the following Centers for Medicare & Medicaid Services (CMS) Web sites:

- ***www.cms.hhs.gov***
  (CMS Home page)
- ***www.cms.hhs.gov/coverage***
  (Medicare Coverage Home page)
- ***www.cms.hhs.gov/medicare***
  (Medicare Information Resource)
- ***www.cms.hhs.gov/providers***
  (Medicare Providers Web page)
- ***www.cms.hhs.gov/suppliers/dmepos***
  (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information Resource for Medicare)
- ***www.cms.hhs.gov/manuals***
  (Medicare and Medicaid Program Instructions)

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at ***www.cms.gov/providerupdate***. We encourage you to bookmark this Web site and visit it often for this valuable information.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update ListServe at ***list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1***.

[Reference: Change Request (CR) 2686; Transmittal AB-03-075]

New Online CMS Manual System

Beginning October 1, 2003, the Centers for Medicare & Medicaid Services (CMS) will transition from a paper-based manual system to a Web-based system. The process includes the streamlining, updating, and consolidating of CMS' various program instructions

into an electronic Web-based manual system for all users. The new system is called the online CMS Manual System and is located at ***www.cms.hhs.gov/manuals***.

The new online CMS Manual System will be organized by functional area (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity). The functional orientation of the new manual will eliminate significant redundancy within the manuals and will streamline the updating process, thus making CMS program instructions available in a more timely and accessible fashion.

Specifically, the CMS Manual System will include the following functional areas:

- Pub. 100-01 Medicare General Information, Eligibility, and Entitlement
- Pub. 100-02 Medicare Benefit Policy
- Pub. 100-03 Medicare National Coverage Determinations
- Pub. 100-04 Medicare Claims Processing
- Pub. 100-05 Medicare Secondary Payer
- Pub. 100-06 Medicare Financial Management
- Pub. 100-07 Medicare State Operations
- Pub. 100-08 Medicare Program Integrity
- Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications
- Pub. 100-10 Medicare Quality Improvement Organization
- Pub. 100-11 Reserved
- Pub. 100-12 State Medicaid
- Pub. 100-13 Medicaid State Children's Health Insurance Program
- Pub. 100-14 Medicare End Stage Renal Disease Network Organization
- Pub. 100-15 Medicare State Buy-In
- Pub. 100-16 Medicare Managed Care
- Pub. 100-17 Medicare Business Partners Systems Security
- Pub. 100-18 Medicare Business Partners Security Oversight
- Pub. 100-19 Demonstrations
- Pub. 100-20 One-Time Notification

The table below identifies what current paper-based manuals were used to construct the new Internet-only manuals. It is just a cursory overview. A detailed crosswalk is being developed to guide you from a specific section of the old manual to where the information now appears in the new manuals. In addition, the Internet-only manual will have a crosswalk to show how the information in each section was derived.

Paper-Based Manuals	***Internet-Only Manuals***
Pub. 06 Medicare Coverage Issues	**Pub. 100-01** Medicare General Information, Eligibility, and Entitlement
Pub. 09 Medicare Outpatient Physical Therapy	**Pub. 100-02** Medicare Benefit Policy
Pub. 10 Medicare Hospital	**Pub. 100-03** Medicare National Coverage Determinations
Pub. 11 Medicare Home Health Agency	**Pub. 100-04** Medicare Claims Processing
Pub. 12 Medicare Skilled Nursing Facility	**Pub. 100-05** Medicare Secondary Payer
Pub. 13 Medicare Intermediary Manual, Parts 1, 2, 3, and 4	**Pub. 100-06** Medicare Financial Management
Pub. 14 Medicare Carriers Manual, Parts 1, 2, 3, and 4	**Pub. 100-08** Medicare Program Integrity
Pub. 21 Medicare Hospice	**Pub. 100-09** Medicare Contractor Beneficiary and Provider Communications
Pub. 27 Medicare Rural Health Clinic and Federally Qualified Health Center	
Pub. 29 Medicare Renal Dialysis Facility	
Program Memoranda	
Pub. 60A Intermediaries	
Pub. 60B Carriers	

Paper-Based Manuals	*Internet-Only Manuals*
Pub. 60AB Intermediaries/Carriers ***NOTE:*** Information derived from Pub. 06 to Pub. 60AB was used to develop Pub. 100-01 to Pub. 100-09 for the Internet-only manual.	
Pub. 19 Medicare Peer Review Organization	**Pub. 100-10** Medicare Quality Improvement Organization
Pub. 07 Medicare State Operations	**Pub. 100-07** Medicare State Operations
Pub. 45 State Medicaid	**Pub. 100-12** State Medicaid **Pub. 100-13** Medicaid State Children's Health Insurance Program
Pub. 81 Medicare End Stage Renal Disease Network Organizations	**Pub. 100-14** Medicare End Stage Renal Disease Network Organizations
Pub. 24 Medicare State Buy-In	**Pub. 100-15** Medicare State Buy-In
Pub. 75 Health Maintenance Organization/ Competitive Medical Plan **Pub. 76** Health Maintenance Organization/ Competitive Medical Plan (PM) **Pub. 77** Manual for Federally Qualified Health Maintenance Organizations	**Pub. 100-16** Medicare Managed Care
Pub. 13 Medicare Intermediaries Manual, Part 2 **Pub. 14** Medicare Carriers Manual, Part 2	**Pub. 100-17** Business Partners Systems Security
Pub. 13 Medicare Intermediaries Manual, Part 2 **Pub. 14** Medicare Carriers Manual, Part 2	**Pub. 100-18** Business Partners Security Oversight
Demonstrations (PMs)	**Pub 100-19** Demonstrations
Program instructions that impact multiple manuals or have no manual impact.	**Pub 100-20** One-Time Notification

[Reference: Change Request (CR) 2886; Transmittal 2]

Telephone Numbers

Caller Information Network	
Supplier Toll-Free Line	866-419-9458
Beneficiary Toll-Free Line	800-842-2052
Beneficiary Toll-Free Line (PA only)	800-Medicare
EDI Services Help Desk	866-861-7348
Program Education & Training	570-735-9666
Program Inquiries	
Telephone Reviews Line	866-420-6906
Voice Mail (Hearings)	570-735-9513
FAX Numbers	
Check Control/MSP	570-735-9594
Electronic Data Interchange	570-735-9510
Extra Documentation	570-735-9402
Program Education & Training	570-735-9442
Program Inquiries (Hearings & Reconsideration)	570-735-9599
National Supplier Clearinghouse	866-238-9652
SADMERC	877-735-1326

Web Sites

www.umd.nycpic.com
www.cms.hhs.gov

Addresses

Accounting
P.O. Box 6900
Wilkes-Barre, PA 18773-6900
[*for Check Control/MSP*]

Administrative Law Judge (ALJ)
Hearings and Fair Hearings
P.O. Box 450
Wilkes-Barre, PA 18703-0450

Drugs Claims
P.O. Box 587
Wilkes-Barre, PA 18703-0587

General Correspondence
P.O. Box 1363
Wilkes-Barre, PA 18703-1363
[*for Written Inquires, Freedom of Information Act (FOIA), Medicare Secondary Payer (MSP)*]

Mobility/Support Surfaces Claims
P.O. Box 599
Wilkes-Barre, PA 18703-0599

Oxygen Claims
P.O. Box 508
Wilkes-Barre, PA 18703-0508

PEN Claims
P.O. Box 877
Wilkes-Barre, PA 18703-0877

Program Inquires/Reviews
P.O. Box 6300
Wilkes-Barre, PA 18773-6300

Reviews
P.O. Box 1068
Wilkes-Barre, PA 18703-1068
[*for Written Reconsiderations*]

Specialty Claims
P.O. Box 1246
Wilkes-Barre, PA 18703-1246
[*for all other claim types not listed above*]

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

MEDICARE

DMERC A
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

A CMS Contracted Carrier