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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[Editor's Note: The following information was correct at time of publication - please visit our Web site for recent updates.]

IMPORTANT REMINDER TO SUPPLIERS

DMERC A Publications for Fiscal Year 2003

As previously published in the *DMERC Medicare News*, the Centers for Medicare & Medicaid Services (CMS) has given a specified maximum budget for fiscal year 2003 (FY03) for each contractor's level of effort used to provide educational services. The Region A Durable Medical Equipment Regional Carrier (DMERC A) has changed its publication processes to make the most of the available funding, most notably, as related to the Program Safeguard Contractor (PSC).

CMS awarded a Medicare Program Safeguard Task Order to TriCenturion, LLC. As the PSC for Region A, TriCenturion assumed responsibility for medical policy development, medical review, and benefit integrity for Region A durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims. TriCenturion maintains a Web site at ***www.tricenturion.com***. The PSC Web site contains information on:

- Fraud and Abuse
- Healthcare Common Procedure Coding System (HCPCS)
- Local Medical Review Policies (LMRPs) [draft and final]

Updates and changes involving the above topics will no longer be published in the quarterly bulletins, nor posted to our Web site at ***www.umd.nycpic.com***. Instead, suppliers should visit the PSC Web site to access this information directly from the PSC, including recent updates under the "What's New" section. Suppliers should continue to visit the DMERC A Web site for information regarding billing, educational updates/events, electronic data interchange (EDI), fee schedules, what's new, etc.

Providers can obtain additional information by visiting the following CMS Web sites:

- ***cms.hhs.gov/providerupdate*** (CMS Quarterly Provider Update)
- ***cms.hhs.gov/medicare*** (Medicare Professional and Technical Information)
- ***cms.hhs.gov/manuals/memos*** (Program Memos)
- ***cms.hhs.gov/manuals/transmittals*** (Program Transmittals)
- ***cms.hhs.gov/manuals/108_pim*** (Medicare Program Integrity Manual)
- ***cms.hhs.gov/manuals/14_car*** (Medicare Carriers Manual)
- ***cms.hhs.gov/manuals/06_cim*** (Medicare Coverage Issues Manual)

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DMERC A Contacts

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

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

Billing Reminder - Beneficiary Eligibility

When an individual becomes entitled to health insurance benefits, he/she receives a health insurance card with his/her name, sex, health insurance claim number (HICN), and the effective dates of entitlement to hospital insurance and medical insurance. The individual or his/her physician or other supplier must show the HICN on the request for Medicare payment.

Proper identification of the beneficiary is essential in processing any claim. Incorrect or incomplete beneficiary names and claim numbers cause delays in claims processing and increases in administrative expenses. The most reliable means of getting this information is to copy the data from the beneficiary's Medicare card. If this is not possible or practical, the identifying information may already be available in the physician's or supplier's records, or it may be obtained by contacting the beneficiary.

Also, the Medicare secondary payer (MSP) provisions found in Section 1862(b) of the Social Security Act, make Medicare secondary payer to insurance plans and programs in the following situations:

1. Working Aged - Medicare is secondary to group health plans (GHPs) of employers and employee organizations, including multiemployer and multiple employer plans which have at least one participating employer that employs 20 or more employees. Medicare is secondary for Medicare beneficiaries age 65 or older who are covered under the plan by virtue of their own current employment status with an employer or the current employment status of a spouse of any age.
2. Working Disabled - Medicare is secondary to large group health plans (LGHPs), i.e., plans of employee organizations and employers when at least one of the employers employs at least 100 employees. Medicare is secondary for Medicare beneficiaries who are under age 65, entitled to Medicare on the basis of disability, and are covered under the plan by virtue of their own or a family member's current employment status with an employer.
3. End Stage Renal Disease (ESRD) - Medicare is secondary to GHPs (without regard to the number of individuals employed and irrespective of current employment status) that cover individuals who have ESRD. Except as provided in Section 3335.4E of the Medicare Carriers Manual (MCM), GHPs are always primary payers throughout the first 30 months of ESRD-based Medicare eligibility or entitlement.
4. Workers' Compensation (WC) - Medicare is secondary to WC plans (including black lung benefit programs) of the States and the United States.
5. No-Fault - Medicare is secondary to any no-fault insurance, including automobile medical and nonautomobile no-fault insurance.
6. Liability - Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance).

In addition to the above, beneficiaries may have Medicaid and/or Medigap insurance. Therefore, it is important for physicians and suppliers to obtain **correct and complete** beneficiary identification information in order to expedite the processing of their Medicare claims.

Billing Reminders - Capped Rental Items

For efficient and effective use of Medicare operational and program resources, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should submit their claims on a monthly basis. The following reminders will benefit suppliers by helping to maximize claims processing accuracy and to reduce the likelihood of a claim denial:

Wheelchair Accessories: When billing wheelchair accessories with the **RR** modifier (used when wheelchair is rented) for two (2) or more units of service, bill each unit with the appropriate modifiers on separate claim lines (e.g., bill K0042LTRR with one unit of service on one line and K0042RTRR with one unit of service on a second line).

Clarification of Requirements for Maintenance and Servicing: Suppliers must not submit claims for maintenance and servicing until all claims for rental have been paid and six (6) months have passed from the end of the final paid rental month (see Medicare Carriers Manual (MCM), Section 5102.1.E.4). Failure to follow these instructions may cause claims to deny.

If there is no evidence of a Certificate of Medical Necessity (CMN), the maintenance and service claim will be denied. Furthermore, suppliers should **not** bill for maintenance and servicing codes (**MS** modifier) on the same claim as codes for the rental itself.

Change Requests On the Internet

Article references can be found at these Web sites:
cms.hhs.gov/manuals/memos; or
cms.hhs.gov/manuals/transmittals.

Skilled Nursing Facility (SNF) Consolidated Billing - New Requirements for Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Medicare pays for DMEPOS when it is medically necessary for use in a patient's home. If a beneficiary using DMEPOS is at home on the "from" date or anniversary date, Medicare will make payment for the DMEPOS for the entire month, even if the "from" date is the date of discharge from the SNF. However, if a beneficiary using DMEPOS is in a covered Part A stay in an SNF for a full month, Medicare will not make payment for the DMEPOS for that month.

For capped rental items, if the covered Part A SNF stay overlaps the anniversary date ("from" date on the claim) of the Certificate of Medical Necessity (CMN), and the beneficiary is not in the covered Part A SNF stay for the entire month, the date of discharge becomes the new anniversary date ("from" date on the claim) for subsequent claims. In this situation, the supplier must submit a new claim with the date of discharge as the new anniversary date upon the beneficiary's release from the SNF. Suppliers should annotate the HA0 record (Item 19 for paper claims) to indicate that the patient was in an SNF, resulting in the need to establish a new anniversary date.

[Reference: Change Request 2453 (CR); Transmittal B-02-087]

Revision to Messages for Skilled Nursing Facility (SNF) Consolidated Billing

Effective April 1, 2003, remark code N73, provided in Change Requests 1764, 1955 and 2082, has been revised to a more generic format to address a variety of situations. The current remittance advice message will be revised to the following:

Adjustment reason code 109 - Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor.

Remark code N73 - A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.

Per the Balanced Budget Act, services provided by Clinical Social Workers (CSWs) to beneficiaries in a Part A SNF stay may not be billed separately to the carrier. Payment for these services is included in the prospective payment rate paid to the SNF. Though the policy has been in effect since April 1, 2001, there were no corresponding edits. **Effective April 1, 2003**, the Common Working File (CWF) will have a new edit established for services rendered to these beneficiaries with dates of service on or after April 1, 2001, for claims received on or after April 1, 2003. When carriers receive the new reject code, they will deny the claim and use the following remittance advice message:

Adjustment reason code 96 - Non-covered charges.

Remark code N121 - Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.

[Reference: Change Request (CR) 2360; Transmittal B-02-067]

Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing

In April 2001, the Centers for Medicare & Medicaid Services (CMS) established via Program Memorandum (PM) the process of periodically updating 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). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs), will **not** be paid on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Note that items incidental to physician services, as well as supplies used in institutional settings, are not subject to HH consolidated billing.

PM Transmittal AB-03-002 (Change Request 2515) issues the second quarterly HH consolidated billing update for calendar year 2003, **effective April 1, 2003**. This update adds a single non-routine supply code to the list of codes subject to consolidated billing. This code was identified through additional review of the annual HCPCS update that was reflected in the first quarterly update. However, it was identified too late for inclusion in Medicare systems changes for the January quarter. Other updates for the remaining quarters of the calendar year will occur as needed due to the creation of new temporary codes representing services subject to HH consolidated billing prior to the next annual update.

The new code to be added is:

A6440 (Zinc Paste >=3" <5" w/roll)

Providers and suppliers interested in an updated complete list of codes subject to HH consolidated billing should refer to the HH consolidated billing master code list available at ***cms.hhs.gov/medlearn/refhha.asp***.

Reminder: Is your National Supplier Clearinghouse (NSC) number currently active to bill Medicare?

New Modifier Needed to Invoke ABN Logic for Hardcopy and Electronic Claims

The Centers for Medicare & Medicaid Services (CMS) recently implemented the Advanced Beneficiary Notice (ABN) and the Free Upgrade initiatives (please see articles published in the September 2001 and December 2001 *DMERC Medicare News*). If the supplier uses an ABN or dispenses a free upgrade, the supplier must submit the line item using two of three modifiers (GZ or GA and GK) with an ABN item and one modifier when offering a free upgrade (GL modifier). The VIPS Medicare System (VMS) can only hold four (4) modifiers per line item. In those cases where more than 4 modifiers are necessary, CMS has established the following modifier:

KB Beneficiary Requested Upgrade for ABN, more than 4 Modifiers Identified on Claim
*(Note: The **KB** modifier only applies to claims for DMEPOS where the supplier obtained an ABN.)*

Effective July 1, 2003, suppliers must pay attention to the placement order of overflow modifiers as follows:

- Paper claims: When a supplier is billing more than 4 modifiers, the supplier must replace the fourth modifier with the new **KB** modifier and place the remaining ABN modifiers in Item 19, indicating the line to which they apply.
- National Standard Format (NSF) claims: When a supplier is billing more than 4 modifiers, the supplier must replace the fourth modifier with the new **KB** modifier and place the remaining ABN modifiers in HA0 record per claim line.
- American National Standards Institute (ANSI) claims: When a supplier is billing more than 4 modifiers, the supplier must replace the fourth modifier with the new **KB** modifier and place the remaining ABN modifiers in 2400-NTE02 (NTE01+ADD).

These requirements relate to the ABN used for **beneficiary-requested** DMEPOS upgrades only and will enable the claims processing staffs at the durable medical equipment regional carriers (DMERCs) to manually invoke ABN logic on the applicable claims.

[Reference: Change Request (CR) 2048; Transmittal B-03-009]

EDI & HIPAA

Implementation Date Change to Process ICD-9-CM Codes

The Centers for Medicare & Medicaid Services (CMS) previously issued Program Memorandum B-02-064 (Change Request 2209, dated October 11, 2002), which required Medicare contractors to process International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes using date of service (DOS) and not date of receipt (DOR). This requirement is also a Health Insurance Portability and Accountability Act (HIPAA) requirement.

Due to problems associated with processing these claims (obsolete ICD-9-CM codes on rental claims), the effective date for turning the VIPS Medicare System (VMS) edits on has changed from January 1, 2003, to April 1, 2003. Therefore, **effective April 1, 2003**, all claims submitted with **deleted truncated** ICD-9-CM diagnosis codes will be returned as unprocessable and will need to be resubmitted with a current code. (Note: Any claim is considered unprocessable if it has incomplete, missing, or invalid information.) The current listing of ICD-9-CM diagnosis codes is available via the CMS Web site at ***cms.hhs.gov/medlearn/icd9code.asp***.

Check for updates on the DMERC A Web site (***www.umd.nycpic.com/dme_what's_new.html***) and in future editions of the *DMERC Medicare News*.

[Reference: Change Request (CR) 2558; Transmittal B-03-002]

Use of the NDC for Drug Claims

Program Memorandum (PM) Transmittal B-03-012 (Change Request 2339, released on February 7, 2003) implements the National Drug Code (NDC) in processing claims for prescription drugs, biologicals, and vaccines (hereafter referred to as "drugs") at the durable medical equipment regional carriers (DMERCs). This action is in compliance with requirements mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191). Although HIPAA applies to electronic transactions, which includes electronic claims, this PM extends the new standards to include paper claims, also for reasons of administrative simplification.

Therefore, claims **submitted either electronic or paper** by all retail pharmacies must comply with the standard formats identified in HIPAA. The NDC must be used to identify retail drugs on all claims submitted to Medicare using the National Council for Prescription Drug Programs (NCPDP) format.

Claims submitted for all drugs from retail pharmacies to the DMERCs must be identified by an NDC and **submitted on or after July 1, 2003**, unless an Administrative Simplification Compliance Act (ASCA) extension has been requested. Healthcare Common Procedure Coding System (HCPCS) codes submitted by retail pharmacies to the DMERCs will be rejected.

For drug claims from retail pharmacies, the NDC must be entered as follows in the NCPDP electronic format:

NCPDP V5.1,
Product/Service ID (Field 407-D7)

Paper claims are capable of containing the 11-digit NDC in Item 24D of the claim form. A modifier cannot be included in Item 24D if an NDC is entered; therefore, the modifier, if appropriate, and supporting documentation, if any, must be supplied in Item 19. Suppliers must put the line number in front of the modifier in Item 19.

Drug information, including the NDC Directory, can be obtained from the Food and Drug Administration (FDA) by accessing its Web site at ***www.fda.gov***. The FDA can be contacted by email at DRUGPRODUCTS@CDER.FDA.GOV or by writing to the following address:

Food and Drug Administration
Information Management Team HFD-095
5600 Fishers Lane
Rockville, Maryland 20857

Specific NDC issues may be directed to 301-594-5467. The fax number is 301-594-6463.

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.

Great News: Access to Eligibility Information via VPIQ

Effective January 1, 2003, VIPS Provider Inquiry System (VPIQ) eligibility is now open to both participating and non-participating providers. Eliminate time (on hold) waiting for customer service to check eligibility; check unlimited eligibility online.

If you would like to sign up to use VPIQ for claim status, why not go the extra step and also check eligibility online. One easy step is all it takes - fill out an Eligibility Inquiry Agreement and mail it to:

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

To obtain the Eligibility Inquiry Agreement via the DMERC A Web site:

- Visit ***www.umd.nycpic.com/edidocfiles.html***
- Click on "On-line Claim Status Inquiry/VPIQ/Eligibility Inquiry"
- Click on "Eligibility Inquiry Agreement"
- Print the form, review the access information, then mail the completed form to the above address.

VPIQ Access

To access the VIPS Provider Inquiry System (VPIQ), providers must fill out an IVANS Service Agreement. To obtain the form via the DMERC A Web site:

- Visit ***www..umd.nycpic.com/edidocfiles.html***
- Click on "IVANS Service Agreement" (this is a PDF file)
- Print the form, then mail the completed form to the address listed on the service agreement, or fax both pages to 813-282-7029.

Providers without Internet access should contact the Electronic Data Interchange (EDI) Help Desk at 570-735-9429 to request either of the above forms.

Connecting to IVANS/AT&T Network in New York City as of February 1, 2003

As of February 1, 2003, the local phone company (Verizon) is requiring that if you are making phone calls within New York City area codes (212, 646, 718, 917, or 347) you will now need to dial 1 and the area code to locations within those same area codes. It is the same way you make a long distance call, however, you will not be charged for a long distance call if you are making a call from the same area code. Seven-digit phone calls will no longer be accepted and a recording will prompt you to dial the full 11-digits based on the area code you are in.

This will affect the way you dial-up to the IVANS/AT&T network via your dial-up connection. If the phone number you are using falls under one of the area codes (212, 646, 718, 917, or 347), you will need to update your dial-up connection with the following steps:

Step 1 - Check the "Traveling user" box

Step 2 - Select the phone number - city you are dialing

Step 3 - In the number to dial drop down box, add "1" + area code - phone number

The connection will still be charged as a local call, but you will not be able to connect if you do not include the full 11-digits. We have listed below the dial-up numbers in New York City that will require 11-digit dialing.

New York:	212-796-1285
New York:	212-796-1835
New York:	212-824-2405
New York:	347-834-0105
Staten Island:	718-354-3925

If you have any questions or problems with your connection, please call our Tampa support center at 1-800-548-2675 for assistance.

HIPAA Changes

Don't get left behind; get all the up-to-date facts on the changing Health Insurance Portability and Accountability Act (HIPAA) information on the DMERC A Web site at ***www.umd.nycpic.com/emc&hipaa.html***.

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

Attention Accelerate Software Users: Updates to the POS Code Set

The following place of service (POS) codes have been added as of January 1, 2003:

- 03 - School
- 04 - Homeless Shelter
- 15 - Mobile Unit
- 20 - Urgent Care Facility

If you are using the Accelerate software to bill DMERC A, you will be unable to bill the above codes. **The above codes will need to be billed on paper.** Due to the implementation of the Health Insurance Portability and Accountability Act (HIPAA) transaction sets, we will not be making any changes to the Accelerate software at this time. We apologize for any inconvenience this may cause.

Please check the EDI section of the DMERC A Web site (***www.umd.nycpic.com/dmedi.html***), beginning in March 2003, for the HIPAA-compliant software order form. We will commence sending out the new HIPAA software sometime near the middle of April. The new software will allow you to bill these POS codes. If you have any questions, please contact the Electronic Data Interchange (EDI) Help Desk at 570-735-9429.

Electronic Patient Records Via Non-Internet Means

This is a reminder that the Region A Durable Medical Equipment Regional Carrier (DMERC A) will not accept extra documentation on a claim via the Internet. Extra documentation ***must*** be faxed to 570-735-9510, 48 hours prior to submitting your claims electronically. Please use the Extra Documentation cover sheet for any documentation sent to our office.

The Extra Documentation cover sheet is available via the DMERC A Web site at ***www.umd.nycpic.com/extra.html***. Providers without Internet access should contact the Electronic Data Interchange (EDI) Help Desk at 570-735-9429 to request the form.

[Reference: Change Request (CR) 2264; Transmittal AB-02-145]

HIPAA Information on the DMERC A Web site

The Centers for Medicare & Medicaid Services (CMS) provided the Region A Durable Medical Equipment Regional Carrier (DMERC A) with two Adobe® Portable Document Format (PDF) files containing information on the Health Insurance Portability and Accountability Act (HIPAA). These files have been posted on the DMERC A Web site at ***www.umd.nycpic.com/emc&hipaa.html*** with the titles "CMS HIPAA Electronic Transactions & Code Sets Information" and "Provider HIPAA Readiness Checklist - Getting Started."

The "CMS HIPAA Electronic Transactions & Code Sets Information" file explains what HIPAA is, who is impacted, why it is being implemented, and steps providers should take to prepare. It also includes timelines and useful tips to assist the implementation process. The "Provider HIPAA Readiness Checklist - Getting Started" file outlines five (5) areas providers need to address, and the key points to consider for each area, regarding the HIPAA requirements. The areas include: 1) determining if you are covered by HIPAA, 2) assigning a HIPAA point person, 3) familiarizing yourself with the key HIPAA deadlines, 4) determining how HIPAA affects you, and 5) talking to the health plans and payers you bill most frequently.

In order to download and view these two files, refer to the article "Downloading PDF Files from the DMERC A Web Site" on page 23.

Remittance Advice Remark and Reason Code Update

X12N 835 Health Care Remittance Advice Remark Codes: The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010 Implementation Guide (IG). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment.

The list of remark codes is available at ***cms.hhs.gov/providers/edi/hipaadoc.asp*** and ***www.wpc-edi.com/hipaa***, and the list is updated each March, July, and November. The following list summarizes changes made through October 31, 2002.

New Remark Codes:

Code	Current Narrative
N117	This service is paid only oncein a lifetime per beneficiary.
N118	This service is not paid if billed more than once every 28 days.
N119	This service is not paid if billed once every 28 days, and thepatient has spent 5 or more consecutive days in any inpatient or SNF (Part B) facility within those 28 days.
N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Beneficiary transferred or was discharged/readmitted during payment episode.
N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.
N122	Mammography add-on code can not be billed by itself.
N123	This is a split service and represents a portion of the units from the originally submitted service.
N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.
N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay. If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision. You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

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Code	Current Narrative
	The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.
N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.
N127	This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.
N128	This amount represents the prior to coverage portion of the allowance.
N129	This amount represents the dollar amount not eligible due to the patient's age.
N130	Consult plan benefit documents for information about restrictions for this service.
N131	Total payments under multiple contracts cannot exceed the allowance for this service.
N132	Payments will cease for services rendered by this US Government debarred or excluded provider after the 30-day grace period as previously notified.
N133	Services for predetermination and services requesting payment are being processed separately.
N134	This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
N135	Record fees are the patient's responsibility and limited to the specified co-payment.
N136	To obtain information on the process to file an Appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
N137	You, the provider, acting on the Member's behalf, may file an appeal with our Company. You, the provider, acting on the Member's behalf, may file a complaint with the Commissioner in the state of Maryland without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.
N138	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.
N139	Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
N140	You have not been designated as an authorized OCONUS provider, therefore, are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.

Code	Current Narrative
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
N143	The patient was not in a hospice program during all or part of the service dates billed.
N144	The rate changed during the dates of service billed.
N145	Missing/incomplete/invalid provider identifier for this place of service.
N146	Missing/incomplete/invalid/not approved screening document.
N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.
N148	Missing/incomplete/invalid date of last menstrual period.
N149	Rebill all applicable services on a single claim.
N150	Missing/incomplete/invalid model number.
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
N152	Missing/incomplete/invalid replacement claim information.
N153	Missing/incomplete/invalid room and board rate.
N154	This payment was delayed for correction of provider's mailing address.
N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
N156	The patient is responsible for the difference between the approved treatment and the elective treatment.

Modified Remark Codes:

Code	Current Narrative
M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

continued next page...

Code	Current Narrative
	If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.
M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). You may make the request through any Social Security office or through this office.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.
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 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified 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. If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.

Code	Current Narrative
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 reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days. An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified 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 Section1879 of the Social Security Act, and the patient chooses not to appeal.
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. An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a reasonable and necessary 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.
N22	This procedure code was changed because it more accurately describes the services rendered.
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 ***cms.hhs.gov***.

X12 N 835 Health Care Claim Adjustment Reason Codes: The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee 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 3 times a year after each X12 trimester meeting at ***www.wpc-edi.com/hipaa***. The committee approved the following reason code changes in October 2002:

New Reason Codes:

Code	Current Narrative
149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many services.
152	Payment adjusted because the payer deems the information submitted does not support this length of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.

Modified Reason Codes:

Code	Current Narrative
35	Lifetime benefit maximum has been reached

continued next page...

Retired Reason Codes:

Code	Current Narrative
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. (Inactive for version 4050)
88	Adjustment amount represents collection against receivable created in prior overpayment. (Inactive for version 4050)

The effective date for this update is **April 1, 2003**.

[Reference: Change Request (CR) 2546; Transmittal AB-03-012]

October 2002 Changes for X12N 837 (4010) - Coordination of Benefits (COB)

Beginning October 7, 2002, X12N 837 (4010) COB transactions will be updated to meet specific Health Insurance Portability and Accountability Act (HIPAA) data requirements. As a result of this upgrade, the X12N 837 (4010) COB transactions are to be generated with complete HIPAA-compliant data elements. There are situations when an inbound claim received on paper, in non-version 4010 electronic format, or 837 (4010) format, will lack data elements or contain data that do not meet the data attribute (e.g., alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements. In most cases, claims with invalid data are rejected, but in limited cases, a claim could be accepted and adjudicated. It is also possible to receive data from the Common Working File that may not meet the X12N 837 (4010) Implementation Guide requirements for COB. The Centers for Medicare & Medicaid Services (CMS) requires that the flat file created by our system for COB have all of the requirements and applicable conditional data elements for generating a HIPAA-compliant X12N 837 outbound COB transaction. Our system will "gap fill" data when issuing an outbound X12N 837 (4010) COB transaction unless data is available from history, store and forward repository (SRF), or reference files:

1. For "gap filling" purposes, leading and trailing spaces will not be considered significant characters.

2. The Implementation Guide states, "If either NM108 or NM109 is present, then the other is required." For "gap filling" purposes, the following conditions are being considered when NM108 is a "situational" or "required" data element - if NM108 contains a valid value and NM109 contains a value with a leading space, NM109 will be "gap filled" with "99."

3. All NM103, NM104, NM105, NM107, PER04, PER06, PER08, N201, N301, N302, REF02, CN104, CN106, K301, NTE02, CR109, CR110, CR210, CR211, MOA03, MOA04, MOA05, MOA06, MOA07, HI101-2, HI102-2, HI103-2, HI104-2, HI105-2, HI105-2, HI106-2, HI107-2, HI108-2, HCP04, HCP06, SV101-2, PS101, HCP04, HCP06 and HCP10 fields will be evaluated for compliance and will be "gap filled" with "UNKNOWN."

4. All PRV03 fields will be evaluated for compliance and will be "gap filled" with "203B00000X."

5. All N401 (exception 2330 loop) fields will be evaluated for compliance and will be "gap filled" with "UNKNOWN."

6. All N402 (exception 2330 loop) and CLM11-4 fields will be evaluated for compliance and will be "gap filled" with "FC."

7. All N403 (exception 2330 loop) fields will be evaluated for compliance and will be "gap filled" with "00000."

8. All N404 (exception 2330 loop) and CLM11-5 fields will be evaluated for compliance and will be "gap filled" with "ZZ."

9. All DMGR02 fields will be evaluated for compliance and will be "gap filled" with "19660701."

10. CLM01 field will be evaluated for compliance and will be "gap filled" with "0."

11. CR702, CR703, HSD06 in 2305 loop fields will be evaluated for compliance and will be "gap filled" with "9."

12. SBR03 and SBR04 in 2320 loop fields will be evaluated for compliance and will be "gap filled" with "UNKNOWN."

13. CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 in 2320or 2420 loops fields will be evaluated for compliance and will be "gap filled" with "UNKNO."

14. N401, N402, N403 and N404 in 2330 loop fields will be evaluated for compliance and will be "gap filled" with spaces. If the whole 2330A.N4 segment contains spaces, the segment will not be created.

15. SV101-3, SV101-4, SV101-5, SV101-6 in 2400 loop fields will be evaluated for compliance and will be "gap filled" with spaces.

Further Guidance Regarding a Remittance Advice if Required Data is Missing or Invalid from a Claim

The X12 835 version 4010 Implementation Guide (IG) contains specific data requirements which must be met to build an electronic remittance advice (ERA) in compliance with the Health Insurance Portability and Accountability Act (HIPAA). When a claim is received on paper, or in a pre-4010 or other electronic format, it could lack data or have data that does not meet the data attribute or length requirements for preparation of a HIPAA-compliant ERA. If it is not rejected as a result of standard or IG level editing, the Region A Durable Medical Equipment Regional Carrier (DMERC A) will send a "gap filled" ERA to avoid non-compliance with HIPAA. The following table indicates the "gap fill" values that DMERC A customers may receive on an X12 835 electronic remittance advice:

IG Page	Segment	Loop	Field Name	"GAP Fill" Value
49	BPR09		ACCOUNT NUMBER	UNKNOWN
63	N102	1000A	NAME (Payer)	UNKNOWN
64	N301	1000A	ADDRESS INFO (Payer)	UNKNOWN
65	N401	1000A	CITY NAME (Payer)	UNKNOWN
65	N402	1000A	STATE OR PROVINCE CODE (Payer)	FC (Foreign Country)
65	N403	1000A	POSTAL CODE (Payer)	00000
73	N102	1000B	NAME (Payee)	UNKNOWN
74	N301	1000B	ADDRESS INFORMATION (Payee)	UNKNOWN
74	N302	1000B	ADDRESS INFORMATION (Payee)	UNKNOWN
75	N401	1000B	CITY NAME (Payee)	UNKNOWN
89	CLP01	2100	CLAIM SUBMITTER'S IDENTIFIER	0
103	NM103	2100	NAME LAST OR ORG NAME (Patient)	UNKNOWN
103	NM104	2100	NAME FIRST (Patient)	UNKNOWN
104	NM109	2100	IDENTIFICATION CODE (Patient)	99
109	NM103	2100	NAME LAST OR ORG NAME (Corrected Information)	UNKNOWN
109	NM104	2100	NAME FIRST (Corrected Information)	UNKNOWN
110	NM109	2100	IDENTIFICATION CODE (Corrected Information)	99
115	NM103	2100	NAME LAST OR ORG NAME (Crossover)	UNKNOWN
115	NM109	2100	IDENTIFICATION CODE (Crossover)	99
117	NM103	2100	NAME LAST OR ORG NAME (Corrected Payer)	UNKNOWN
117	NM109	2100	IDENTIFICATION CODE (Corrected Payer)	99

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.

Identifying the Primary Payer Amounts When There Are Multiple Primary Payers on Electronic and Hardcopy Claims

There are situations where more than one primary payer pays on a Medicare Part B claim and Medicare may still make a secondary payment on the claim. Physician and suppliers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the 837 version 4010 Professional Implementation Guide regarding the submission of Medicare beneficiary claims to multiple payers for payment. Providers must follow model 1 in section 1.4.2.1 that discusses the provider to payer to provider methodology of submitting electronic claims. When there are multiple primary payers to Medicare, you must follow the instructions cited below when sending the claim to Medicare for secondary payment.

Submission of Electronic MSP Claims With Multiple Primary Payers, but With Only One Insurance Type Code: Where there is more than one primary payer on a MSP claim and the primary payers identify the same insurance type code (e.g., the claims show two employer group health plans made payment on the claim which is identified as insurance type code 12), physicians and suppliers can send these claims electronically using the 837 version 4010 claim submission format. When sending these types of claims, you must do the following:

Primary Payer Paid Amounts: For line level services claims, physicians and suppliers must add all primary payer paid amounts for that service line and put the total amount in loop ID 2430 SVD02 of the 837. If only claim level information is sent to Medicare, providers and suppliers must add all other payer paid amounts for that claim and place the total amount in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount: For line level services, physicians and suppliers must take the higher of the allowed amount for that service line, or the total of the other payer paid amounts, whichever is higher, and put the amount in loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837. If only claim level information is sent to Medicare, take the higher of the claim level allowed amount, or the total of the other payer paid amounts, whichever is higher, and put the amount in Loop ID 2320 AMT02 AMT01 = B6.

Obligated to Accept as Payment in Full Amount (OTAF): For line level services, physicians and suppliers must take the lowest OTAF amount for that service line, which must be greater than zero, and put the amount in loop 2400 CN102 CN 101 = 09. If only claim level information is sent to Medicare, take the lowest claim level OTAF amount, which must be greater than zero, and put this information in loop 2300 CN102 CN101 = 9.

Submission of Hardcopy MSP Claims With Multiple Primary Payers, but With More Than One Insurance Type Involvement: There may be situations where two or more insurer types make payment on a claim; for example, an auto insurer makes a primary payment on a line of service and, subsequently, a group health plan also makes a primary payment for the same line of service. Claims with more than one insurance type involvement cannot be sent electronically to Medicare. **A hardcopy claim must be submitted.** Use the current HCFA-1500 form when submitting Part B hardcopy claims. Physicians and suppliers must attach the other payers' explanation of benefits (EOB), or remittance advice, to the incoming claim when sending it to Medicare for processing.

[Reference: Change Request (CR) 2050; Transmittal AB-03-011]

Updates: American National Standards Institute (ANSI)

Error Code Manual: The latest version of the ANSI Error Code Manual is available via the DMERC A Web site at ***www.umd.nycpic.com/emc&hipaa.html#ANSI-Error-code***. (Note: This is an Adobe® Portable Document Format (PDF) file.)

Vendor Listing: All vendors who provide software for claim submission to Medicare are required to pass testing of the 837 transaction successfully before they or their clients may transmit claims to the DMERCs. For your convenience, we have compiled a list of vendors who have successfully passed the 837 transaction with the DMERC A. These vendors are approved for submission of the 837 transaction, and the list is updated on a regular basis at ***www.umd.nycpic.com/ANSI_listing.html***.

Miscellaneous

Provider Notification of Denials Based on Local Medical Review Policy (LMRP)

Beginning April 1, 2003, Change Request 2305, Transmittal AB-02-184 requires contractors to give notice to Medicare providers when claims are denied in part or in whole based on application of an LMRP. The Centers for Medicare & Medicaid Services (CMS) has created a new Remittance Advice (RA) remark code to be used in conjunction with existing messages to accomplish this (see below).

N115 This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at ***www.LMRP.net***, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP.

Providers must know why their claims are denied, so they can decide whether to appeal those claim denials and so they will know how to avoid such denials, if desired, in the future.

The LMRPs for Region A are also available via the Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com***, or by calling the Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier toll-free line at 866-419-9458.

Correction - Accounting P.O. Box

It has been brought to our attention that a typographical error is within the article "Establishment of New P.O. Boxes," on page 12 of the December 2002 *DMERC Medicare News*. The article states that the post office box for accounting issues is P.O. Box 6300; however, the post office box is actually P.O. Box 6900. We apologize for the confusion.

Reminder - New P.O. Boxes

All mailings to the Region A DMERC are handled under the same timeliness parameters, regardless of the mailing method, including Certified Mail. Therefore, the following post office (P.O.) boxes should be utilized:

P.O. Box 450 Hearings and Administrative Law Judge (ALJs)

P.O. Box 508 Oxygen Claims [*Oxygen and Oxygen Equipment; Respiratory Assist Device (RAD); Continuous Positive Airway Pressure (CPAP) System; Ventilators; Cough Stimulating Device; Intrapulmonary Percussive Ventilation (IPV) System*]

P.O. Box 587 Drugs Claims [*Infusion; Immunosuppressive; Nebulizers; Oral Anti-Cancer; Oral Anti-Emetic; End Stage Renal Disease (ESRD); Epoetin (EPO)*]

P.O. Box 599 Mobility/Support Surfaces Claims [*Power Operated Vehicle (POV); Hospital Beds and Accessories; Repairs; Motorized/Power Wheelchair Base; Manual Wheelchair Base; Wheelchair Options and Accessories; Seating Systems, Back Module; Pressure Reducing Support Surfaces-Groups I, II and III; Miscellaneous Support Surfaces; Pneumatic Compression Device (for Lymphedema)*]

P.O. Box 877 PEN Claims [*Parenteral Nutrition; Enteral Nutrition (including E0776 and A5200)*]

P.O. Box 1068 Reviews

P.O. Box 1246 Specialty Claims [*All other claim types not listed above*]

P.O. Box 1363 General Correspondence Inquiries

Please refer to this listing to identify the types of claims, categorized by policy group, for the proper P.O. box. **(NOTE: If there are several policy groups on a claim, submit the claim to the P.O. box referencing the policy group on the first claim line.)**

Please note, P.O. Box 6900 will remain in effect for accounting issues (e.g., refund checks), and P.O. Box 6800 will remain in effect for all other correspondence issues.

Fee Updates for 2003

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

- Surgical Dressing Codes
- 2003 Ostomy Code Fees
- 1st Quarter 2003 Update: Oral Anticancer Drug Fees
- 1st Quarter 2003 Update: Drug Fees
- 2003 National Payment Limits for Therapeutic Shoes
- 2003 Parenteral and Enteral Fees

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 a hardcopy version by writing to:

HealthNow New York Inc.
DMERC A
Attention: FOIA
P.O. Box 1363
Wilkes-Barre, PA 18773-1363

Note: The April quarterly update for the 2003 DMEPOS fee schedule will be posted to the DMERC A Web site when the information is available from the Centers for Medicare & Medicaid Services (CMS).

[Reference: Change Request (CR) 2535; Transmittal AB-03-006]

Region A DMERC Supplier Manual

The Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier manual is currently being revised into a new and improved edition. Notification of its availability will be posted to the DMERC A Web site at ***www.umd.nycpic.com/dme_what's_new.html***, and the online version will be replaced with the new edition.

Due to budgetary constraints, the new edition will initially be available for current providers via the Web site. New providers will continue to receive a hardcopy manual.

Look for additional information on the availability of the new and improved supplier manual on the Web site and in future editions of the *DMERC Medicare News*.

Overpayments - Refunds and Offsets

Please refer to the following for accounting refund issues:

Documentation of the Overpayment Refund Form

When using an overpayment refund form to identify a refund due to the Region A Durable Medical Equipment Regional Carrier (DMERC A), it is important to include all pertinent information regarding the request. If the reason for the overpayment is due to the return of rental or purchased equipment, please use reason code 17 (Other), and include code, date of service, and date of pick up or return (for example: K0001 for date of service 1/1/03 was returned on 12/30/02). In addition, if only one code on a claim is to be adjusted, document the appropriate code on the bottom of the form (e.g., patient returned 2 units of A4253 for date of service). This will alleviate unnecessary delays in processing the refund request.

A copy of the overpayment refund form has been provided on the next page for your convenience.

Mail completed forms and documentation to:

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

Notification of Offset

The term offset, used in relation to an overpayment, is when payment due a provider is applied to any outstanding delinquent receivable. Recent changes to the provider remittance notice now include a "provider adjustment details" line. This entry notifies the provider of any adjustment to claims listed on the remittance. It also informs the provider of any offsets to the account.

When an adjustment has been done, the reason code will be "CS." If the adjustment results in an overpayment, a request for repayment will be sent in the form of an overpayment/demand letter. If an offset occurs, the reason code will be "WO" and the FCN field will contain a corresponding number that refers to the receivable document control number (DCN) to which funds have been applied.

Overpayment Refund Form

To Be Completed By Medicare Contractor	
Contractor Deposit Control #:	Date:
Contractor Contact Name:	Date of Deposit:
Contractor Address:	Telephone #:
	Contractor Fax:

To Be Completed By Provider/Physician/Supplier		
Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.		
Provider/Physician/Supplier Name:		Provider/Physician/Supplier Number:
Address:		Contact Person:
		Telephone #:
Check Number:	Check Date:	Check Amount:

Refund Information

Please provide the following for each claim (list all claim numbers involved; attach separate sheet if necessary).

[*Note*: If specific patient/HIC/claim number/claim amount data not available for all claims due to statistical sampling, please indicate methodology and formula used to determine amount and reason for overpayment.]

Patient Name:	HIC Number:
Claim Number:	Claim Amount Refunded: $

Reason Code for Claim Adjustment: (Select reason code from list. Use one reason per claim.)

Billing/Clerical	Error MSP/Other Payer Involvement	Miscellaneous
01 - Corrected Date of Service	08 - MSP Group Health Plan Insurance	13 - Insufficient Documentation
02 - Duplicate	09 - MSP No Fault Insurance	14 - Patient Enrolled in an HMO
03 - Corrected CPT Code	10 - MSP Liability Insurance	15 - Services Not Rendered
04 - Not Our Patient(s)	11 - MSP, Workers' Comp. (including Black Lung)	16 - Medical Necessity
05 - Modifier Added/Removed	12 - Veterans Administration	17 - Other (please specify)
06 - Billed in Error		
07 - Corrected CPT		

For Institutional Facilities Only:
Cost Report Year(s) (If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

For OIG Reporting Requirements:
Do you have a Corporate Integrity Agreement with OIG? ☐ Yes ☐ No

Program Education & Training

Spring 2003 Seminars

The Region A Durable Medical Equipment Regional Carrier (DMERC A) announces the spring 2003 continuing education seminars and workshops. These sessions are being offered at **no charge**. Topics for the sessions include DMERC 101 (basic billing), Documentation/Certificates of Medical Necessity (CMNs), Medicare Program Billing Updates, and Wheelchair, Vision, and Pharmacy Billing. The workshops are being offered as two-day sessions; however, you may attend any session(s) you wish. Please visit the DMERC A Web site at *www.umd.nycpic.com* for more information and details on what will be covered in each session.

Dates and Locations

Date	Location	Address	Telephone
March 26, 2003 (*Modified Session)	Luzerne County Community College Educational Conference Center	1333 S. Prospect Street Nanticoke, PA	570-740-0311
April 7-8, 2003	Ramada Inn at Amoskeag Falls	21 Front Street Manchester, NH	603-669-2660
April 10-11, 2003	Rhode Island Convention Center	One Sabin Street Providence, RI	718-565-8900
April 30-May 1, 2003	Resorts Atlantic City	1133 Boardwalk Atlantic City, NJ	609-340-6826
May 13-14, 2003	Avalon Hotel	16 W. 10th Street Erie, PA	814-459-2220
May 20-21, 2003	Quality Inn	3 Watervliet Ave. Ext. Albany, NY	518-438-8431
May 29-30, 2003	Luzerne County Community College Educational Conference Center	1333 S. Prospect Street Nanticoke, PA	570-740-0311

*Modified Session (March 26, 2003):

8:30 AM - 9:00 AM	Registration
9:00 AM - 12:00 PM	Documentation/CMNs
1:00 PM - 4:00 PM	Wheelchair Billing

The remaining sessions are two-day programs with the following agendas:

Day One Seminar Agenda:

8:30 AM - 9:00 AM	Registration
9:00 AM - 11:30 AM	DMERC 101 (basic billing)
1:00 PM - 3:30 PM	Documentation/CMNs
5:30 PM - 7:30 PM	Vision Billing

Day Two Seminar Agenda:

8:30 AM - 9:00 AM	Registration
9:00 AM - 11:30 AM	Wheelchair Billing
1:00 PM - 3:30 PM	MedicareProgram Billing Updates
5:30 PM - 7:30 PM	Pharmacy Billing

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

How to Register

All attendees **must** be registered in advance. **You may now submit your registration online.** The registration form is available on the DMERC A Web site (***www.umd.nycpic.com/dmprovcaln.html***) under "Events." **Registrations are due no later than one week prior to the seminar.** Due to limited space, registration is on a first come, first served basis. In the event that a particular session is filled to capacity, you will be notified by telephone. The DMERC A reserves the right to cancel any seminar. If this occurs, you will be notified.

Note: Confirmations will be sent via email. If you do not receive your confirmation within five (5) days of the event for which you have registered, please call the Program Education & Training Department at 570-735-9666 and select Option 1. **Please contact the hotels directly for information regarding overnight accommodations, parking, and driving directions.**

If you do not have Internet accesss, please call 570-735-9666, Option 1, and **leave your name, company name, telephone number, and fax number**, and a registration form will be sent to you.

DMERC A Provider Communications Advisory Group Update

The second quarterly meeting for fiscal year 2003 of the Provider Communications (PCOM) Advisory Group was held via teleconference on January 8, 2003. Participants included representatives from the Centers for Medicare & Medicaid Services (CMS), TriCenturion, LLC, the Program Safeguard Contractor (PSC) for Region A, state provider associations for Region A, and individual provider organizations. The agenda consisted of discussion on educational opportunities, review of data analysis, and plans for the spring 2003 seminars. Presentations were given by DMERC A representatives on the Privacy Act and beneficiary consent procedures, the quality program within the Customer Information Network (CIN) Department, and the Next Generation Desktop (NGD) initiative, a CMS-mandated tool that will be utilized by CIN representatives as a more efficient means of providing excellent customer service. The group discussed several other "hot topic issues," such as the Health Insurance Portability and Accountability Act (HIPAA) and the upcoming telephone review process. In addition, dialogue on the establishment of collaborative workgroups, which will include members of the PCOM Advisory Group, the PSC, and the DMERC A, to address global issues of concern in the provider community (i.e., Advanced Beneficiary Notifications (ABNs) and repair claim issues) took place during the meeting.

PCOM Advisory Group meetings for the remainder of fiscal year 2003 are scheduled as follows:

Date	Location
April 9, 2003	Newark, NJ [*Note:* The site for this meeting will be posted to the DMERC A Web site (***www.umd.nycpic.com***) at a later date.]
July 9, 2003	Teleconference [*Note:* This is a change from previously published information.]

Members will be notified via email of the details and registration process prior to each meeting. Check our Web site for the development of a PCOM Advisory Group page, which will feature details on upcoming meetings, online membership and registration, and meeting minutes, including the materials distributed at each meeting.

The Program Education & Training (PET) Department encourages any and all interested representatives to become a member of the PCOM Advisory Group. It is important to ensure our targeted educational efforts are both meaningful and helpful to the provider community as a whole. **If you would like more information regarding the PCOM Advisory Group, or if you wish to become a member, please contact the PET Department at 570-735-9666 and select Option 1.** Membership is FREE.

For additional details on the PCOM Advisory Group and its purpose, please refer to the article on page 15 in the December 2002 *DMERC Medicare News*.

Claim Submission Errors for the First 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). Below are the top ten CSEs for the first quarter of fiscal year 2003, which ran from October 1, 2002, to December 31, 2002. During this timeframe, there were **109,296** errors on claims submitted electronically to the 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. The DMERC A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please share this information with your colleagues.

Claim Submission Error	Correction - Electronic	Correction - Paper	Errors
1) and 2) Other Carrier's Name and Address (OCNA) number is missing or invalid. This is used for a secondary insurance crossover. The OCNA number can be found on the DMERC A Web site at ***www.umd.nycpic.com/OCNA_01-02.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.	7,803
3) Service "from" and "to" dates cannot span years. [Effective January 1, 2003, the Common Working File (CWF) edits will permit service dates to span years.]	Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in the FA0-605 record. Multiple years (e.g., dates of service 12/15/01-01/14/02) must be on separate claim lines (i.e., one line for each year).	Enter the precise eight-digit date(MMDDCCYY) for each procedure, service, or supply in Item 24A.	7,170
4) Insured's ID number is missing or 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.	6,265
5) Ordering/referring physician's UPIN is missing. Contact the physician, or obtain a copy of all UPINs from the local Part B Medicare offices or via the DMERC A Web site at ***www.umd.nycpic.com/dmprovinfo.html*** (UPIN Directory link).	Enter the physician UPIN in the FB1-9 record.	Enter the physician UPIN in Item 17A.	4,760
6) Invalid insurance type. Physicians and suppliers must enter information required if requested by the beneficiary.	Enter the insurance type in the DA0-6 record. See the National Standard Format (NSF) manual or matrix for acceptable values.	Enter the insured's policy or group number in Item 11, if insurance is primary to Medicare. If Medicare is primary, enter "NONE."	3,220
7) Beneficiary's address is invalid.	Enter the patient's street address on the first line, and the issued to 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.	Enter the patient's complete street address on the first line in Item 5.	3,083
8) Invalid diagnosis pointer. This field cannot be blank, and it is used to relate the date of service and the procedure performed to the diagnosis. When multiple services are performed, enter the primary reference number for each service (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.	2,926
9) Invalid patient signature source.	Enter the patient signature source in the DA0-16 record. See the NSF manual or matrix for acceptable values.	Enter the patient signature information in Item 12.	2,871
10) Invalid source of payment indicator. Participating physicians and suppliers must enter information required if requested by the beneficiary.	Enter the indicator in the DA0-5 record. See the NSF manual or matrix for acceptable values.	Enter the insured's policy or group number in Item 11, if insurance is primary to Medicare. If Medicare is primary, enter "NONE."	2,656

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.

DMERC A Web Site - Valuable Information Resource

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site features information the Centers for Medicare & Medicaid Services (CMS) issues for publication, links to *DMERC Medicare News* articles, and information that is important for suppliers to know. To access the DMERC A Web site:

- Visit ***www.umd.nycpic.com***
- Click on "DMERC A"
- Click on "Suppliers" to see a description of each category you can visit in this section of the Web site

Updates to the DMERC A Web site occur regularly and may contain more information than the *DMERC Medicare News*. Suppliers are encouraged to visit the DMERC A Web site. Check it out TODAY!!

Recent Enhancement:

A new search engine has been installed within the DMERC A Web site, so online searches will be processed quicker and minus non-related results.

Look for additional enhancements in the near future.

Subscribe to the DMERC A ListServe

The DMERC A ListServe is a no-charge feature, which is used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. Subscribers will also receive notice of the availability of the quarterly *DMERC Medicare News* on our Web site.

If you wish to subscribe to the DMERC A ListServe (***www.umd.nycpic.com/dmlistserve.html***), type your email address in the box provided, then click the "Submit" button.

Reminder - Downloading PDF Files from the DMERC A Web Site

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For more information on PDF, see the article on page 18 in the December 2002 *DMERC Medicare News*.

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