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 enclosed information was correct at time of publication - visit our Web site for recent updates.

Testing and Other Help Available Before the October 16, 2003, Compliance Date for HIPAA Transaction and Code Set Standards

The following information is from the Centers for Medicare & Medicaid Services (CMS) Administrator, Thomas A. Scully, regarding the upcoming Health Insurance Portability and Accountability Act (HIPAA) compliance deadline.

Dear Medicare Provider,

Will you be ready to bill Medicare effective October 16?

Should you be concerned about getting your Medicare claims paid starting October 16? If you are not ready to use the HIPAA standard transaction and code sets by October 16, you may not get paid!

HIPAA is more than a privacy law; it touches many aspects of health care, including the bills you submit to all health insurers, not just Medicare. Effective October 16, 2003, all electronic transactions covered by HIPAA must comply with these standards for format and content. For example, the electronic claim that a physician or hospital sends to a health plan must be compliant and health plans are only allowed to process compliant transactions. Any non-compliant claims submitted after the October deadline will be returned to you, unpaid.

You may have thought that you can still submit paper bills to Medicare, but in many cases, this is not true. The Administrative Simplification Compliance Act (ASCA) includes a provision that requires electronic submissions to Medicare effective October 16, 2003, with a few exceptions.*

CMS and its contractors are eager to help you through this transition. Testing with your carrier or fiscal intermediary is required to assure that you and your business partners can send and receive HIPAA compliant transactions. Medicare contractors are ready to test with you now! To schedule testing, contact your Medicare carrier or fiscal intermediary. For more information, please review the helpful HIPAA resources, shown below.

Although we have all been working hard to achieve HIPAA compliance and the benefits it will bring, there is still much to be done. Time is growing short; please be sure to test and start sending and receiving HIPAA compliant transactions as early as possible to avoid any last-minute problems.

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

* One of the major exceptions is for claims submitted by "a small provider of services or supplier." The term "small provider of services or supplier" is defined to mean: a provider of services with fewer than 25 full-time equivalent employees; or a physician, practitioner, facility or supplier (other than provider of services) with fewer than 10 full-time equivalent employees. There will be other limited exceptions.

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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 Telephone Reviews Line	866-420-6906
EDI Helpdesk	570-735-9429	Program Inquiries Voice Mail (Hearings)	570-735-9513
Extra Documentation Fax	570-735-9402	SADMERC	877-735-1326

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Helpful HIPAA Resources

Upcoming Satellite Broadcasts

HIPAA 101 - The Basics of Administrative Simplification
July 16, 2003, 2:00 - 3:00 p.m. ET
July 30, 2003, 2:00 - 3:00 p.m. ET

[*Editor's Note: Check the below Web site for future satellite broadcasts regarding HIPAA and Administrative Simplification.*]

www.cms.hhs.gov/medlearn

Register to be a host site for satellite broadcasts.

www.cms.hhs.gov/hipaa/hipaa2

General HIPAA Information
Educational Materials
Frequently Asked Questions
HIPAA Administrative Simplification Information Series for Providers
Links to Additional HIPAA Web Pages

www.eventstreams.com/cms/tm_001

View HIPAA educational Webcast on the following topics:

HIPAA Basics
Provider Steps for Getting Paid Under HIPAA

askHIPAA@cms.hhs.gov

Request answers to your HIPAA Administrative Simplification questions.

866-282-0659

HIPAA hotline staff will answer your HIPAA Administrative Simplification questions or direct you to the appropriate resources.

Local Carriers and Fiscal Intermediaries

HIPAA scheduling and testing.

Suppliers who are interested in testing with the Region A Durable Medical Equipment Regional Carrier (DMERC A) can register for testing via our Web site at *www.umd.nycpic.com/dmehipaa.html*, or they may contact the Electronic Data Interchange (EDI) Department at 570-735-9429 or via email at *team.edi@healthnow.org*.

Interim Final Rule for Electronic Submission of Medicare Claims

On August 15, 2003, the Department of Health and Human Services (HHS) published the Final Rule for Electronic Submission of Medicare Claims. This rule implements the statutory requirement found in the Administrative Simplification Compliance Act (ASCA). ASCA requires (with a few exceptions) all claims sent to the Medicare program be submitted electronically starting October 16, 2003. ASCA was enacted by Congress to improve the administration of the Medicare program by increasing efficiencies gained through additional electronic claims submission. Although 86.1 percent of Medicare claims are submitted electronically, the volume of paper claims is substantial, and moving from paper to electronic submissions has the potential for significant savings for Medicare physicians, practitioners, suppliers, and other healthcare providers, as well as for the program itself. This Rule sets forth the details for implementation of the Medicare electronic claims submission requirement and who may be exempt from these requirements.

The rule is available at
a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2003/pdf/03-20955.pdf

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 Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site at *www.umd.nycpic.com/emc&hipaa.html*.

Billing

End Stage Renal Disease (ESRD) Claims Submission Procedures

Only a supplier that is not a dialysis facility may submit a claim to a Durable Medical Equipment Regional Carrier (DMERC) for home dialysis supplies and equipment. For purposes of home dialysis, a skilled nursing facility (SNF) may qualify as a beneficiary's home. Suppliers will submit these claims via a CMS-1500 form or electronic equivalent.

Under Method II, beneficiaries may not submit any claims and cannot receive payment for any benefits for home dialysis equipment and supplies. In accordance with the Code of Federal Regulations (CFR), Method II patients who self-administer erythropoietin (EPO) may only obtain EPO from either their Method II supplier, or a Medicare certified ESRD facility.

For additional information regarding ESRD claims submission, refer to the article "New End Stage Renal Disease (ESRD) Billing Procedures" on page 5 in the March 2002 *DMERC Medicare News*. For provisions specific to home dialysis supplies and equipment, refer to the Region A DMERC medical policy available via the Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/lmrp_current_dyn.cfm***.

[Reference: Change Request (CR) 2747; Transmittal 1803]

Annual Update of the ICD-9-CM Code Set

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes are updated annually. **Effective October 1, 2003**, an ICD-9-CM code is required on all paper **and** electronic claims billed to Medicare contractors with the exception of ambulance supplier claims (specialty type 59).

Providers can access the new, revised and deleted ICD-9-CM codes on the Centers for Medicare & Medicaid Services (CMS) Web site at ***www.cms.hhs.gov/medlearn/icd9code.asp***. This CMS Web site contains the new, revised, and deleted ICD-9-CM codes that are effective for dates of service on or after October 1, 2003. Also, providers are encouraged to visit the National Center for Health Statistics (NCHS) Web site at ***www.cdc.gov/nchs/icd9.htm***.

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

- Government Printing Office: 866-512-1800
- Ingenix: 877-INGENIX (877-464-3649)
- American Medical Association: 800-621-8335

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

[Reference: Change Request (CR) 2763; Transmittal AB-03-091]

ICD-9-CM Coding - Increased Role for Physicians/Practitioners

Effective for dates of service on or after October 1, 2003, **valid** ICD-9-CM diagnosis codes must be included on **all** electronic and paper claims billed to the Region A Durable Medical Equipment Regional Carrier (DMERC A), with the exception of ambulance claims. Providers and suppliers rely on physicians to provide a diagnosis code or narrative diagnostic statement on orders/referrals. Therefore, physicians/practitioners must ensure they include *specific* diagnosis information on all orders and referrals. Failure to do so will result in claims processing delays and nonpayment of Medicare-covered services.

Providers and suppliers should refer to the article "ICD-9-CM Coding," on page 7 in the June 2003 *DMERC Medicare News*, and the article titled "ICD-9-CM Coding Requirements," on the "Billing" page of our Web site at ***www.umd.nycpic.com/dmbilltips.html***, for additional information regarding claims submission.

[Reference: Change Request (CR) 2784; Transmittal B-03-046]

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Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Claims During an Inpatient Stay

For capped rental items of durable medical equipment (DME) where the DME supplier submits a monthly bill, the date of delivery ("from" date) on the first claim must be the "from" or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the fifteenth of the following months (October 15, November 15, etc.).

When the "from" date on the DMEPOS claims falls within an inpatient stay, and the beneficiary returns home within the same calendar month, the supplier must submit a new claim on the date of discharge from the institutional provider and the date of discharge will become the "from" (anniversary) date for all subsequent claims.

Suppliers should annotate the HA0 record in National Standard Format (NSF) claims, 2300 NTE and 2400 NTE for American National Standards Institute (ANSI) claims, or Item 19 for paper claims (CMS-1500), to indicate that the patient was in an institution, resulting in the need to establish a new anniversary date.

[Reference: Change Request (CR) 2613; Transmittal B-03-055]

Special Optional Requirements for Immunosuppressive Drugs

Inpatient facilities (e.g., hospitals) are responsible for providing all drugs a beneficiary needs while the beneficiary is an inpatient in the facility. The Durable Medical Equipment Regional Carriers (DMERCs) make payment for immunosuppressive drugs for beneficiaries who receive a covered organ transplant and who meet all other Medicare coverage criteria for immunosuppressive drugs once the patient has returned to his/her home. Suppliers are required to obtain a properly completed DMERC Information Form (DIF) prior to submission of claims for immunosuppressive drugs for use in the home.

It is reasonable to expect that a pharmacy, knowing the patient is going to be discharged, may want to obtain a DIF for the patient up to two (2) days prior the date the patient will be discharged. Similarly, the supplier may operate by mail-order and may wish to put the drugs in the mail two days prior to the date a patient will be discharged, so that the drugs will be at the patient's home when he/she returns.

Under normal circumstances, the date of service listed on the claim must be the date the supplier actually delivered or mailed the item. However, under the circumstance described above, the systems will, appropriately, reject the claim with a date of service listed as being prior to the patient's date of discharge, because the hospital remains responsible for the provision of immunosuppressive drugs while the beneficiary is still an inpatient.

Therefore, in this situation, the pharmacy may enter the date of discharge as both the initial date on the DIF form and as the date of service on the first claim it submits for the beneficiary after the beneficiary is discharged. Note that this is an optional, not mandatory, process. If the pharmacy does not want to obtain the DIF or dispense the immunosuppressive drugs prior to the beneficiary's date of discharge from the hospital, it may wait for the beneficiary to be discharged before doing so and follow all applicable Medicare and DMERC rules for immunosuppressive drug billing (e.g., the date of service will be the date of delivery).

Note that the following conditions apply:

1) The facility remains responsible for all immunosuppressive drugs required by the beneficiary for the duration of the beneficiary's inpatient stay. The pharmacy must not receive separate payment for immunosuppressive drugs prior to the date the beneficiary is discharged.

2) The pharmacy must not obtain the DIF or mail or otherwise dispense the drugs any earlier than two days before the patient is discharged. It is the pharmacy's responsibility to confirm the patient's discharge date if it chooses to take advantage of this option.

3) The pharmacy must not submit a claim for payment prior to the beneficiary's date of discharge.

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4) The beneficiary's discharge must be to a qualified place of service (e.g., home, custodial facility), but not to another facility (e.g., inpatient hospital or skilled nursing facility) that does not qualify as the beneficiary's home.

[Reference: Change Request (CR) 2731; Transmittal 1804]

Refractive Lenses Policy - Coding Change

Effective July 1, 2003, code A9270 is to be used when billing for polycarbonate lenses. In the past, providers were instructed to use code V2799 with a narrative description (polycarbonate lenses).

Providers need to continue billing with two claim lines when submitting claims for polycarbonate lenses. On line 1, enter the standard lens code and modifiers. On line 2, enter the A9270.

Please refer to the TriCenturion, Region A Program Safeguard Contractor (PSC), Web Site at ***www.tricenturion.com/content/lmrp_current_dyn.cfm*** for the Refractive Lenses medical policy.

Collection of Fee-for-Service Payments Made During Periods of Managed Care Enrollment

This article provides guidance for physicians, providers, and suppliers regarding overpayment recovery activities that the Centers for Medicare & Medicaid Services (CMS) will undertake connected to erroneous approvals for payment of fee-for-service (FFS) claims during periods of managed care enrollment.

The 1999 Balanced Budget Reconciliation Act (BBRA) requires "current month enrollment," which means that the effective date of enrollment is based upon the date a beneficiary signs an application for enrollment in a Medicare+Choice Organization (M+CO). The effective date of enrollment, as well as the date the M+CO is responsible for providing Medicare services to the beneficiary, is the first day of the month following receipt of the beneficiary's completed, signed application for enrollment in the M+CO.

The CMS electronic data systems may experience time lags, during which time Medicare services and items are paid twice: 1) through the FFS Medicare contractor and 2) through the Managed Care Payment systems in the monthly capitation rate for the beneficiary. When the electronic data systems recognize that a beneficiary has enrolled in a M+CO, the M+CO receives capitation payments for the beneficiary, retroactive to the effective date of enrollment. During the period of time between the effective date of enrollment and when the CMS electronic data system updates, physicians, providers, and suppliers may not be aware of the beneficiary's enrollment in the M+CO and bill the Medicare FFS system for services and items provided to that beneficiary.

Effective October 1, 2003, CMS contractors will initiate overpayment recovery procedures to retract original Part A and Part B payments and generate adjustments to update or cancel claims connected to erroneous approvals for payment of FFS claims during periods of managed care enrollment.

If you have questions about this article, please contact your carrier or intermediary.

Managed Care Enrollment - New Remittance Message

Effective October 1, 2003, Medicare contractors will use the following remittance message when services are rendered during a period when the beneficiary is enrolled in a managed care plan and billing should have been submitted to the managed care plan for payment.

> **Adjustment reason code 24** - Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.

Information regarding the beneficiary's managed care plan will be provided via letter or alternate method.

[Reference: Change Request (CR) 2562; Transmittal AB-03-058]

Quarterly Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing

This is the third quarterly home health (HH) consolidated billing update for calendar year 2003. This update adds three non-routine supply codes to the list of codes subject to consolidated billing. It also removes two codes that are no longer valid for Medicare billing.

The new codes to be added are:

K0614	Chem/antiseptic solution, 8oz
K0620	Tubular elastic dressing
K0621	Gauze, non-impreg pack strip

The codes to be deleted are:

97014	Electric stimulation therapy

These changes are **effective for claims with dates of service on or after October 1, 2003**.

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

[References: Change Request (CR) 2776, Transmittal AB-03-096; Change Request (CR) 2892, Transmittal AB-03-136]

Individual Consideration (IC) Codes - Billing Reminder

When submitting claims for items considered as Individual Consideration codes (codes without a reimbursement amount on the fee schedule, codes with 'IC' on the fee schedule, or codes with zeros on the fee schedule), **include the manufacturer's name and product name/model number for the item**. Failure to furnish this information will result in a denial.

Medicare Services Furnished to Alien Beneficiaries

Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) prohibited aliens who are not "qualified aliens" from receiving Federal public benefits, including Medicare. The term "qualified alien" is defined to include six groups of aliens as follows:

- Aliens who are lawfully admitted for permanent residence under the Immigration and Nationality Act (Act);
- Aliens who are granted asylum under section 208 of the Act;
- Refugees admitted into the United States under section 207 of the Act;
- Aliens who are paroled into the United States under section 212(d)(5) of the Act for a period of at least 1 year;
- Aliens whose deportation is being withheld under section 243(h) of the Act; or
- Aliens who are granted conditional entry pursuant to section 203(a)(7) of the Act as in effect prior to April 1, 1980.

Two groups of qualified aliens were added to the statute after the original enactment of the restriction in the 1996 Welfare Reform statute. These groups are certain Cuban and Haitian entrants to the United States and certain "battered aliens."

Under the terms of the PRWORA, non-qualified aliens could not receive Medicare benefits.

Section 5561 of the Balanced Budget Act of 1997 (BBA) amended section 401 of the PRWORA to create a Medicare exemption to the prohibition on eligibility for non-qualified alien beneficiaries, who are lawfully present in the United States and who meet certain other conditions.

Effective January 1, 2004, under the provisions of the final rule (which is pending publication), payment may be made for services furnished to an alien who is lawfully present in the United States (and, provided that with respect to benefits payable under Part A of Title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], who

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was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for Medicare benefits). The definition for "lawfully present in the United States" is found at 8 CFR 103.12.

Medicare will not make payment for services furnished to an alien beneficiary who is not lawfully present in the United States. Durable Medical Equipment Regional Carriers (DMERCs) will, based on dates of service, deny claims for items and services submitted for alien beneficiaries with **reason code 30**: "Payment adjusted because the patient has not met the required eligibility, spend down, waiting or residency requirements."

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that the beneficiary was lawfully present in the United States on the date of service.

[Reference: Change Request (CR) 2825; Transmittal AB-03-115]

Medicare Billing and the "Do Not Forward" Initiative

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers who serve Medicare beneficiaries must apply for a supplier number in order to submit claims to the Region A Durable Medical Equipment Regional Carrier (DMERC A). The National Supplier Clearinghouse (NSC) is responsible for enrollment of DMEPOS suppliers, and they must have a completed application form (CMS-855S) **before** a supplier may be validated and receive payment.

The application form and instructions are available via the NSC Web site at ***www.palmettogba.com***. Suppliers without Internet access can request an application form by calling the NSC toll-free number (866-238-9652) or by writing to:

National Supplier Clearinghouse (NSC)
P.O. Box 100142
Columbia, SC 29202-3142

Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information ***must*** be reported in writing to the NSC **within 30 days** after such changes have taken place. Visit the NSC Web site or call the toll-free telephone number for instructions. Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

As part of the "Do Not Forward" initiative, DMERC A has been instructed to mail all checks and remittance advices in "Return Service Requested" envelopes. This initiative precludes the forwarding of Medicare checks to locations other than those recorded on the supplier files.

DMERC A will notify the NSC if a check or remittance advice is returned due to an incorrect address and will hold all payments (including electronic funds transfer) and mailings until the NSC confirms the supplier provided the updated information and their file is corrected. Therefore, suppliers should contact the NSC to avoid this scenario. **(*Note*: DMERC A cannot change supplier files.)**

Multiple Primary Payers on Part B Claims

Physicians and suppliers should refer to the following instructions regarding the submission of Medicare Secondary Payer (MSP) claims.

When Medicare is the Secondary Payer Following One Primary Payer

There are situations where one primary payer pays on a Medicare Part B claim and Medicare may make a secondary payment on the claim. Physicians and suppliers must comply with Section 1.4.2, titled "Coordination of Benefits," found in the 837 version 4010 Professional Implementation Guide (IG) regarding the submission of Medicare beneficiary MSP claims (The IG can be found at ***hipaa.wpc-edi.com/HIPAA_40.asp***). Providers must follow Model 1 in Section 1.4.2.1 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. Providers must use the appropriate loops and segments to identify the other payer paid amount, allowed amount, and the obligated to accept payment in full amount on the 837.

Primary Payer Paid Amount:

- For line level services, physicians and suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.
- For claim level information, physicians and suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount:

- For line level services, physicians and suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837.
- For claim level information, physicians and suppliers must indicate the primary payer allowed amount in the Allowed Amount field, loop ID 2320 AMT02 AMT01 = B6.

Obligated to Accept as Payment in Full Amount (OTAF):

- For line level services, physicians and suppliers must indicate the OTAF amount for that service line in loop 2400 CN102 CN 101 = 09. The OTAF amount must be greater than zero.
- For claim level information, physicians and suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero.

When Medicare is the Secondary Payer Following Two Primary Payers (Submission of Hardcopy MSP Claims With Multiple Primary Payers)

There may be situations where more than one primary insurer to Medicare makes payment on a claim; for example, an employer group health plan makes a primary payment for a service and, subsequently, another group health plan also makes a primary payment for the same service. Claims with multiple primary payers **cannot** be sent electronically to Medicare. A hardcopy claim must be submitted on Form CMS-1500. Physicians and suppliers must attach the other payers' explanation of benefits (EOB), or remittance advice, to the claim when sending it to Medicare for processing.

[Reference: Change Request (CR) 2758; Transmittal B-03-050]

Remittance Advice Remark and Reason Code Update

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers, including Medicare, have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment. The current list contains changes (new/modified/retired codes) made through February 28, 2003, and is available via ***www.cms.hhs.gov/providers/edi/hipaadoc.asp*** and ***www.wpc-edi.com/hipaa/***.

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In the current database, five new codes are duplicative and will be deactivated in the next update. These duplicate codes are:

Code	Current Narrative
N164	Transportation to/from this destination is not covered. (*Part B only; not applicable for DMERC claims.*)
N165	Transportation in a vehicle other than an ambulance is not covered. (*Part B only; not applicable for DMERC claims.*)
N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance. (*Part B only; not applicable for DMERC claims.*)
N168	The beneficiary must choose an option before a payment can be made for this procedure/equipment/supply/service.
N169	This drug/service/supply is covered only when the associated service is covered.

Effective October 1, 2003, Medicare contractors and shared system maintainers will use codes N157, N158, N159, N160, and N161 in lieu of N164, N165, N166, N168, and N169. The narratives for these codes are as follows:

Code	Current Narrative
N157	Transportation to and from this destination is not covered. (*Part B only; not applicable for DMERC claims.*)
N158	Transportation in a vehicle other than an ambulance is not covered. (*Part B only; not applicable for DMERC claims.*)
N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance. (*Part B only; not applicable for DMERC claims.*)
N160	The beneficiary/patient must choose an option before this procedure/equipment/supply/service can be covered.
N161	This drug/service/supply is covered only when the associated service is covered.

[Reference: Change Request (CR) 2788; Transmittal AB-03-095]

Update of the Place of Service (POS) Code Set

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction and code set standards **will become effective October 16, 2003**, for all covered entities. Medicare is a covered entity under HIPAA.

Medicare must recognize and accept POS codes from the National POS code set in terms of HIPAA compliance. **Effective October 1, 2003**, the following are the new POS codes the Region A Durable Medical Equipment Regional Carrier (DMERC A) will use for processing claims:

POS Code/Name Description
04/Homeless Shelter A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
13/Assisted Living Facility Congregate residential facility with self-contained living units providing assessment of each resident's needs and onsite support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some healthcare and other services.
14/Group Home Congregate residential foster care setting for children and adolescents in state custody that provides some social, healthcare, and educational support services and that promotes rehabilitation and reintegration of residents into the community.

The complete National POS code set is available on the "Billing" page of the DMERC A Web site at ***www.umd.nycpic.com/dmbilltips.html#POSupdate***, or via the Centers for Medicare & Medicaid Services (CMS) Web site at ***www.cms.hhs.gov/states/poshome.asp***.

[Reference: Change Request (CR) 2730; Transmittal B-03-040]

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NCPDP Companion Document

The National Council for Prescription Drug Programs (NCPDP) Batch Transaction Standard 1.1 Billing Request Companion Document is available on the "EDI & HIPAA" page of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site at ***www.umd.nycpic.com/emc&hipaa.html#NCPDP***. This is a Portable Document Format (PDF) file, therefore, follow the PDF download instructions on the "EDI & HIPAA" page (***www.umd.nycpic.com/emc&hipaa.html)***.

This companion document is based on the NCPDP protocol document for submitting retail pharmacy drug claims in the Telecommunications Standard Specifications and Implementation Guide (IG) version 5.1 and Batch Standard 1.1. It clarifies the DMERC A expectations regarding data submission, processing, and adjudication.

[Reference: Change Request (CR) 2713; Transmittal B-03-041]

Healthcare Provider Taxonomy Codes (HPTC)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standards for conducting certain electronic data interchange health transactions. Some of the implementation guides that were adopted for those standards in the Transactions Final Rule (65**FR**50312) include a data element for the HPTCs. This is the code that identifies the type of healthcare provider involved in furnishing services to beneficiaries.

The National Uniform Claim Committee maintains the HPTC set. The Washington Publishing Company (WPC) makes the code set available on its Web site (***www.wpc-edi.com***). The latest update is dated April 1, 2003, and the new version is 3.0.1.

The Centers for Medicare & Medicaid Services (CMS) also added this crosswalk to their provider enrollment Web site at ***www.cms.hhs.gov/providers/enrollment/***. The list reflects existing Medicare specialty codes to the appropriate HPTC as of April 1, 2003.

[Reference: Change Request (CR) 2766; Transmittal B-03-063]

Guidance on the HIPAA Privacy Rule Business Associate Provisions

Under the business associate provisions of the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule"), Medicare Fee-For-Service (FFS) contractors that perform healthcare activities involving the use of protected health information on behalf of the Medicare FFS health plan (i.e., claims processing functions) are business associates of the Medicare FFS health plan (the covered entity). By definition, a business associate is a person or entity that performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information **on behalf of a covered entity** (45 CFR § 164.103).

Medicare contractors that perform healthcare activities involving the use of protected health information on behalf of the Medicare FFS health plan are **not** business associates of providers, physicians, suppliers or other health plans. Likewise, providers, physicians, suppliers, or other health plans are **not** business associates of the Medicare contractor, unless the provider, physician, supplier or other health plan is doing work on behalf of the Medicare contractor. Consequently, Medicare FFS contractors should not sign business associate agreements with any provider, physician, supplier, or other plan unless the provider, physician, supplier, or other health plan is doing work on their behalf.

For coordination of benefits (COB) purposes, Medicare contractors and trading partners are **not** business associates since neither entity is doing work on the other's behalf; therefore, the Medicare FFS contractors should not sign business associate agreements with supplemental insurers (trading partners). The trading partner agreements (TPAs), executed for the purpose of exchanging adjudicated Medicare claims for secondary liability determination by those partners, are not business associate agreements.

[Reference: Change Request (CR) 2712; Transmittal AB-03-078]

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.

Miscellaneous

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 (see related article on page 16).

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

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]

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Addition of Temporary "Q" Codes for Drugs Used in Infusion Pumps

Effective October 1, 2003, three new "Q" codes have been established for drugs used in infusion pumps. The code descriptions are as follows:

Q4075	Injection, Acyclovir, 5mg
Q4076	Injection, Dopamine Hydrochloride, 40mg
Q4077	Injection, Treprostinil, 1mg

For more information regarding this topic, visit the "What's New" section of the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

[Reference: Change Request (CR) 2805; Transmittal B-03-052]

Coverage of Compression Garments

Effective for items furnished on or after October 1, 2003, gradient compression stockings that serve a therapeutic or protective function and that are needed to secure a primary dressing may be covered as surgical dressings when specific requirements have been met. For more information regarding this topic, visit the "What's New" section of the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

[Reference: Change Request (CR) 2739; Transmittal AB-03-090]

Quarterly 2003 Fee Updates

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

- October Quarterly Update for 2003 DMEPOS Fee Schedule
- July 2003 DME Updates
- 3rd Quarter 2003 Update: Oral Anticancer Drug Fees
  - Oral Anticancer Drug Fee - Correction to 3rd Quarter 2003 Update
- 3rd Quarter 2003 Update: Drug 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:

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

[References: Change Request (CR) 2702, Transmittal AB-03-071; Change Request (CR) 2802, Transmittal AB-03-100]

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Claim Submission Errors for the Third 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 third quarter of fiscal year 2003, which ran from April 1, 2003, to June 30, 2003, are provided in the following chart. During this timeframe, there were **73,926** 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	Errors
1) and 2) Invalid Payer 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.	11,017
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.	5,661
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 DMERC A Web site (UPIN Directory link) at ***www.umd.nycpic.com/dmprovinfo.html***.	Enter the physician's UPIN in the FB1-9 record.	Enter the physician's UPIN in Item 17A.	4,483
5) Beneficiary's address is 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.	Enter the patient's complete street address in Item 5.	2,619
6) Invalid diagnosis pointer. This field cannot be left blank.	Enter the diagnosis code reference number in the FA0-14 record.	Enter the diagnosis code reference number in Item 24E.	2,136
7) 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.)	1,538
8) Invalid beneficiary zip code. This information is required.	Enter the correct zip code in the FB10701 field.	Enter the correct zip code in Item 5.	1,441
9) Ordering physician first name is invalid. This field cannot be left blank and must contain at least one character.	Enter the correct name in the FN10701 field.	Not applicable. (This pertains to electronic claims.)	817
10) Invalid assignment of benefits indicator. This field must be completed if the provider is participating and the patient has Medigap insurance.	Enter the correct indicator in the DA01500 field.	Enter the correct indicator in Item 13.	724

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Provider Communications (PCOM) Advisory Group

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department encourages 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 and members of this group play a vital role in accomplishing this task.

Minutes from the quarterly meetings are available on the DMERC A PCOM Advisory Group Web page at ***www.umd.nycpic.com/dmerc_PCOM.html***. In addition to meeting minutes, this site contains supplementary information on the PCOM Advisory Group, a list of member organizations, and instructions on becoming a member. **Membership is FREE!**

The fourth quarterly meeting for fiscal year 2003 was held via teleconference on July 9, 2003. Participants included representatives from the Centers for Medicare & Medicaid Services (CMS), TriCenturion, LLC, the Program Safeguard Contractor (PSC) for Region A, billing services, state provider associations, and individual provider organizations. Topics addressed at this meeting included:

- Current educational outreach
- Future educational opportunities and plans
- Data analysis
- Role of the Ombudsmen
- PCOM Advisory Group Web page
- Highlights from the June 2003 newsletter
- Next Generation Desktop (NGD)
- Remittance Advice Reason and Remark Codes Initiative by CMS
- Updates from CMS
- Updates on the PCOM Advisory Group workgroups for the Advance Beneficiary Notice (ABN) and Replacement/Repairs, resulting in closure of these initiatives
- Health Insurance Portability and Accountability Act (HIPAA)
- International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) edit process
- Review issues and the telephone review process, which was established on June 1, 2003

The next PCOM Advisory Group meeting is tentatively scheduled for November 12, 2003, in Philadelphia, PA. Members will be notified via email of the details and registration process prior to the meeting.

If you would like more information regarding the PCOM Advisory Group, or if you wish to become a member, please visit our Web page or contact the PET Department at 570-735-9666, and select **option 1**.

CO-16 Missing Information Denial

The Program Education & Training Department routinely compiles and analyzes data to identify areas for education. One of the reports used, the Claim Submission Error Report, consistently reflects "missing information" as one of the top reasons for claim denials. The following is a list of the types of missing information that will cause a CO-16 denial. One or more of these messages will accompany a CO-16 denial and will appear on the remittance notice:

- Did not complete or enter accurately the referring/ordering/supervising physician's name and/or their Unique Physician Identification Number (UPIN) or surrogate
- Secondary payment cannot be made because the primary insurer information was either missing or incomplete
- Incomplete/invalid, procedure codes and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient
- Did not complete or enter the correct physician/physician assistant/nurse practitioner/clinical nurse specialist/supplier billing number/National Provider Identifier (NPI) and /or billing name, address, city, state, zip code, and phone number
- Did not complete or enter accurately an appropriate Healthcare Common Procedure Coding System (HCPCS) modifier
- Incomplete/invalid "from" date of service

A claim lacking any of the above information will be rejected upon submission and will need to be corrected by the provider, then resubmitted for processing. To avoid receiving this denial and experiencing a delay in payment, it is strongly recommended that providers review <u>all</u> claims for accuracy prior to submission.

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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 strongly 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.

To download a PDF:

- Right click on the link for the PDF you wish to download. A menu will pop up on the screen.
- Choose "Save Link As..." or "Save Target As..."
- Choose the location on your computer where you'd like to save the PDF. It is important that you remember this location because you will need it to open the PDF.
- Click on "Save."

To open a PDF:

- Open the Adobe Acrobat Reader software.
- From the "File" menu, choose "Open."
- Find the location on your computer where you saved the PDF file.
- Click "Open."

Once you have the PDF file open, you can print the entire bulletin or select pages using the print option within the Adobe Acrobat Reader software.

To print a PDF:

- From the "File" menu, choose "Print." A menu will pop up on the screen.
- Under the section for "Print Range," choose the option you prefer.
- Click "OK."

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.

Printed Copies of the DMERC A Supplier Manual

The current stock of supplier manuals has been depleted, therefore, the Region A Durable Medical Equipment Regional Carrier (DMERC A) will not offer additional copies for a fee until further notice. Current suppliers, including those enrolled in the Medicare Program during fiscal year 2002, must access the supplier manual on our Web site at ***www.umd.nycpic.com/suppmancopy.html***.

The new edition of the supplier manual was targeted to be posted to our Web site by July 1, 2003. Due to circumstances beyond our control, the new edition will not be posted until further notice. Notification of its availability will be posted to the "What's New" page at ***www.umd.nycpic.com/dme_what's_new.html***. Newly enrolled providers will receive hardcopy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS), once the new edition is available. The new edition will only be available to current providers via our Web site. We apologize for this inconvenience.

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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 in the "Subscribe" section, then click the "Submit" button.

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

Email Address Changes

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***
- Type your **old** email address in the "Unsubscribe" field, then click the "Submit" button
- Type your **new** email address in the "Subscribe" field, then click the "Submit" button

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.

DMERC A to Launch Webcasting Project

The Region A Durable Medical Equipment Regional Carrier (DMERC A) will begin hosting educational seminars and workshops live via the Internet through Webcasting services provided by Webex.

Educational modules from our DMERC 101 Basic Billing seminar will be available through our Web site in the near future. The DMERC A Program Education &Training Department will facilitate these sessions.

We hope providers will share our enthusiasm for this project as we pursue new avenues for providing Medicare information using new technology. Please check the Webex Web site at ***dmercatraining.webex.com*** for updates and announcements of course availability. And, be sure to subscribe to the DMERC A ListServe at ***www.umd.nycpic.com/dmlistserve.html*** to receive notification via your email when courses are scheduled.

HealthNow New York Inc. DMERC A - P.O. Boxes	
P.O. Box 450	Hearings and Administrative Law Judge (ALJ) Hearings
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 System, Back Module, Pressure Reducing Support Surfaces-Groups I, II and III, Miscellaneous Support Surfaces, Pneumatic Compression Device*]
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 [*Written Inquiries, Freedom of Information Act (FOIA), Medicare Secondary Payer (MSP)*]
P.O. Box 6800	Mailing Address
P.O. Box 6900	Accounting

DMERC Medicare News

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

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