DMERC Medicare News

DMERC A ● 866-419-9458 ● www.umd.nycpic.com **Number 70 ● June 2004**

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

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Billing

New Payment Allowance Percentages for DMERC Drugs

Medlearn Matters Number: MM3153
Related Change Request (CR) #: 3153
Related CR Release Date: March 26, 2004
Related CR Transmittal #: 131
Effective Date: January 1, 2004
Implementation Date: March 26, 2004

The following information affects suppliers and other providers who bill for certain drugs and biologicals not paid on a cost or prospective payment basis.

Provider Action Needed

Affected providers and suppliers should note that this instruction adds a payment limit percentage for the drug Capecitabine (Xeloda).

Background

Effective January 1, 2004, the payment limit allowance for J8520 (Capecitabine, 150 mg) and J8521 (Capecitabine, 500 mg) will be 90 percent of the April 1, 2003, Average Wholesale Price (AWP). While this change is effective for these codes as of January 1, 2004, Medicare does not plan to search their files to make any adjustment to claims already processed, unless the provider brings such claims to the attention of their DMERC or fiscal intermediary (FI).

Implementation

The implementation date for this instruction is March 26, 2004.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to:
www.cms.hhs.gov/manuals/pm_trans/R131CP.pdf

If you have any questions, please contact your DMERC/FI at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Frequency Limitations for Darbepoetin Alfa (trade name Aranesp) for Treatment of Anemia in End Stage Renal Disease (ESRD) Patients on Dialysis

Medlearn Matters Number: MM2984
Related Change Request (CR) #: 2984
Related CR Release Date: March 5, 2004
Related CR Transmittal #: 8
Effective Date: April 1, 2004
Implementation Date: April 5, 2004

The following information affects renal dialysis facilities.

Provider Action Needed

Impact to You - Medicare is instituting new frequency limitations for treatment of ESRD patients on dialysis with Darbepoetin Alfa (trade name Aranesp).

What You Need to Know - Be aware of these frequency limitations to assure correct and timely payment for services supplied to Medicare patients.

What You Need to Do - Make sure you understand the changes effective for services provided on and after April 1, 2004, for the frequency limitations on Darbepoetin Alfa for ESRD.

Background

Section 1881(b) (11) (B) of the Social Security Act states that payment will be provided for erythropoietin when a patient diagnosis is ESRD. Darbepoetin Alfa, a new erythropoietin-like product, differs from Epoetin Alfa by the addition of two carbohydrate chains, which lengthens the biologic half-life. This change affects how often the biological can be administered and results in a decreased dosing schedule for Darbepoetin Alfa by comparison to Epoetin Alfa.

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Additional Information

This notice establishes frequency limitations for darbepoetin alfa, and also reiterates the frequency limitations for Epoetin Alfa (trade name EPO) will remain the same. You can refer back to CR2963 for the payment guidelines on Darbepoetin Alfa (trade name Aranesp).

New "K" Codes for Wheelchair Cushions

Effective July 1, 2004, twenty new "K" codes (K0650-K0669) will be established for wheelchair cushions. For more information, please refer to the article "Wheelchair Seating - New Policy" under the March 2004 Bulletins listed on the "What's New" page of the Region A Program Safeguard Contractor Web site at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

[Reference: Change Request (CR) 3069; Transmittal 83]

Manualization of POS Code Set Program Memorandum; Revision to Group Home Code Description

Medlearn Matters Number: MM3087
Related Change Request (CR) #: 3087
Related CR Release Date: March 19, 2004
Related CR Transmittal #: 121
Effective Date: April 1, 2004
Implementation Date: N/A - This is informational only.

The following information affects physicians, suppliers, and providers who bill Medicare carriers.

Provider Action Needed

Physicians, suppliers, and providers should note that this article addresses only a new definition for the Place of Service (POS) Code for Group Homes. Other POS code set information was issued on May 16, 2003, in CMS Program Memorandum/Transmittal B-03-040 and Change Request 2730, "Update of the Place of Service (POS) Code Set." That other information remains unchanged.

Background

Effective April 1, 2004, the description of POS code 14 (Group Home) will be as follows:

> "A residence, with shared living areas, where clients receive supervision and other services, such as social and/or behavioral services, custodial services, and minimal services (e.g. medical administration)."

Once again, the remainder of the updated POS code set remains as presented in Program Memorandum B-03-040, which may be found at: ***www.cms.hhs.gov/manuals/pm_trans/B03040.pdf***

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: ***www.cms.hhs.gov/manuals/pm_trans/R121CP.pdf***

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Payment For Services Provided Under a Contractual Agreement

The following information revises the instructions on reassignment effective immediately.

A carrier may make payment to an entity (i.e., a person, group, or facility) enrolled in the Medicare program that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service may be furnished on or off the premises of the entity submitting the bill. The contractual arrangement between the entity and the physician or other person should include the following program integrity safeguards:

1. Joint and several liability is shared between the entity submitting the claim and the person actually furnishing the service, for any Medicare overpayment relating to such claim.
2. The person furnishing the service has unrestricted access to claims submitted by the entity for the services provided by that person.

[Reference: Change Request (CR) 3083; Transmittal 111]

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Incident-to-Services

Medlearn Matters Number: MM3138
Related Change Request (CR) #: 3138
Related CR Release Date: April 23, 2004
Related CR Transmittal #: 148
Effective Date: May 24, 2004
Implementation Date: May 24, 2004

The following information affects physicians, suppliers, and providers.

Provider Action Needed

Impact to You - This instruction clarifies and standardizes the method of indicating the ordering and supervising professionals on the Centers for Medicare & Medicaid Services Health Insurance Claim Form (CMS-1500). Note that the CMS-1500 is the paper form, however, and is superceded now by the electronic form.

What You Need to Know - This instruction and the CMS Claims Processing Manual update clarifies where physician's Provider Information Numbers and names should be reported when both an ordering provider and a supervising provider are involved in a service.

What You Need to Do - Please refer to the *Background* and *Additional Information* sections of this instruction for further details.

Background

The Centers for Medicare & Medicaid Services (CMS) Health Insurance Claim Form (CMS-1500) is the basic form prescribed by CMS for the submission of claims from physicians and suppliers for the Medicare program. It is used by non-institutional providers and suppliers to bill Medicare Part B covered services and it is also used for billing some Medicaid covered services. It answers the needs of many health insurers and is the basic form prescribed by CMS for the submission of claims on behalf of Medicare patients. (However, please note that the CMS-1500 paper form is superceded by HIPAA electronic formats.)

Because of the multiple requests in Open Door Forums and correspondence, CMS is issuing this instruction **to clarify and standardize the method of indicating the ordering and supervising professionals on the CMS-1500**.

The Preamble of the Proposed Rule for the Medicare Physician Fee Schedule on November 1, 2001 (66 Fed Reg. 55267) stated "**the billing number of the ordering physician (or other practitioner) should not be used if that person did not directly supervise the auxiliary personnel**." This instruction incorporates the rule into the *CMS Claims Processing Manual*.

The update to the *Medicare Claims Processing Manual (Pub 100-4)* (referred to in the Web link below) further clarifies where physician's Provider Information Numbers and names should be reported when both an **ordering provider** and a **supervising provider** are involved in a service.

Implementation

The implementation date is May 24, 2004.

Additional Information

The CMS Manuals Index can be found at the following CMS Web site: ***www.cms.hhs.gov/manuals/cmsindex.asp***

Also, the *Medicare Claims Processing Manual (Pub 100-4)* which was revised can be found at:
www.cms.hhs.gov/manuals/104_claims/clm104index.asp

The official instruction issued to your carrier regarding this change may be found by going to:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3138 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

If you need to contact your Medicaid State Agency for more details, a list of toll-free telephone numbers exists for each Medicaid State Agency at:
www.cms.hhs.gov/medicaid/tollfree.pdf

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2004 Jurisdiction List

Medlearn Matters Number: MM3139
Related Change Request (CR) #: 3139
Related CR Release Date: March 26, 2004
Related CR Transmittal #: 127
Effective Date: May 26, 2004
Implementation Date: May 26, 2004

The following information affects durable medical equipment (DME) suppliers.

Provider Action Needed

DME suppliers should be aware of which Medicare contractor to bill for codes provided on the jurisdiction list of the Healthcare Common Procedure Coding System (HCPCS). This HCPCS list for DME Regional Carrier (DMERC) and local carrier jurisdictions is updated on annual basis to provide accurate billing information to providers.

Ensure that your billing staffs know how to find the list and use the list in their billing processes for Medicare claims.

Background

The HCPCS is updated annually to reflect changes in medical practice and the provision of health care. The Centers for Medicare & Medicaid Services (CMS) provides a file containing updated HCPCS codes to Medicare carriers, DMERCs, and intermediaries and to Medicaid State Agencies 60 to 90 days before the implementation of the annual update.

A spreadsheet containing an updated list of the HCPCS for DMERC and Part B local carrier jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) during each year. CMS publishes a recurring update notification annually to notify the DMERCs and Part B carriers that the list has been updated and is available on the CMS Web site.

Both the DMERCs and the local carriers publish this list to educate providers as to which contractor—the DMERC or local Part B carrier—to bill for codes provided on that list.

Additional Information

Updates are available on an Excel spreadsheet on the CMS Web site at: ***www.cms.hhs.gov/suppliers/dmepos***

The actual instruction issued to the DMERCs may be found at:
www.cms.hhs.gov/manuals/pm_trans/R127CP.pdf

Consolidation of the Claims Crossover Process: Additional Common Working File (CWF) Functionality

Medlearn Matters Number: MM3109
Related Change Request (CR) #: 3109
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R98CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004. Carriers and Durable Medical Equipment Regional Carriers (DMERCs) must complete the Coordination of Benefits Agreement (COBA) claim-based crossover system changes described in this instruction by July 6, 2004. However, because of this instruction's impact on Part B providers and suppliers, the COBA claim-based crossover process will not be operational until October 4, 2004.

The following information affects all Medicare providers.

Provider Action Needed

Medicare physicians, suppliers, and providers should note that this instruction communicates changes to the existing Medicare claims crossover process. The Centers for Medicare & Medicaid Services (CMS) is implementing a new initiative known as the "Coordination of Benefits Agreement (COBA) consolidated crossover process." This article provides guidance on the new COBA crossover strategy, including a new claim-based Medigap and Medicaid crossover process to be implemented by Medicare carriers and DMERCs on October 4, 2004. It is especially important to understand that the new claim-based COBA IDs being issued by CMS to Medigap insurers and State Medicaid Agencies must be submitted on incoming claims in certain defined instances, as explained later in this article.

Background

The Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and

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coordinates the payment process to ensure appropriate payment of Medicare benefits. The program offers an automatic crossover service to other insurers, or trading partners, that may pay benefits after the Medicare claim has been processed. The trading partner is charged a fee-per-claim that is crossed by Medicare. COB trading partners include:

- Medicare supplemental insurers (i.e., non-Medigap plans);
- Title XIX State Medicaid Agencies; and
- Medigap insurers.

In order to better service its customers, CMS is streamlining the claims crossover process and is consolidating the claims crossover function under one contractor, the Medicare Coordination of Benefits Contractor (COBC).

As part of this streamlined process, COB trading partners, who are eligible to receive Medicare paid claims directly from CMS for purposes of calculating their secondary liability, will no longer have to sign separate agreements with individual Medicare carriers and intermediaries. Instead, each COB trading partner will:

- Enter into one national Coordination of Benefits Agreement (COBA) with CMS' consolidated claims crossover contractor (COBC); and
- No longer need to prepare and send separate eligibility files to Medicare intermediaries or carriers, nor receive numerous crossover files. They will instead submit one eligibility file periodically and will regularly receive a consolidated file of claims data for those eligibles.

These changes are the result of input from affected stakeholders in the health insurance industry and will result in a more effective implementation of the COBA process and more effective processes for Medicare providers to receive claim payments that are secondary to Medicare benefits. In addition, the revised COBA process will ensure that CMS fulfills the requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA) ANSI-X12 835 (Electronic Remittance Advice (ERA)) Implementation Guide with respect to communication of crossover information to its Medicare providers and suppliers.

Eligibility-Based Crossover Process

As previously mentioned, national COBAs will now be executed with the COBC by the trading partners and trading partners will send COB eligibility files to the COBC. Trading partners that provide eligibility files will be assigned COBA IDs to facilitate the crossover process.

For an eligibility file-based crossover, the COBA ID of the trading partner, along with all other eligibility file data elements associated to an individual beneficiary, will be stored in Medicare's Common Working File (CWF) in the recently established Beneficiary Other Insurance (BOI) auxiliary record. CWF will also house the COBA Insurance file that will contain specific information associated to the trading partner that is identified on the BOI auxiliary record. As Medicare claims are processed, CWF will be equipped to apply each COB trading partner's claims selection criteria against the Medicare claims and provide information to the Medicare carrier or intermediary to enable those entities to place appropriate crossover claims information on the HIPAA ANSI X12N 835 Electronic Remittance Advice sent to providers and suppliers.

Claim-Based Crossover Process

For those Medigap and Medicaid insurers that do not provide COB eligibility files identifying beneficiaries that are insured by their plans, a claim-based crossover process will be implemented by October 4, 2004. Unique five-digit COBA IDs will be assigned by the COBC to Medigap and Medicaid insurers that do not provide eligibility files to the COBC. Medicare providers and suppliers will receive a listing of all Medigap and Medicaid insurers that have been assigned unique claim-based COBA IDs and will be responsible for entering the unique claim-based COBA IDs on each claim submitted to Medicare to initiate the crossing over of claims to the Medigap or Medicaid insurer for supplemental payment to the provider or supplier.

Through this instruction, Medicare claims processing systems will also be modified to house Medigap and Medicaid claim-based COBA IDs and the associated Medigap or Medicaid information necessary for the Medicare carrier or DMERC to prepare an ERA and send the claim to the COBC to cross to the Medigap or Medicaid insurer. The Part B or DME provider or supplier is required to include a claim-based COBA ID on incoming Medicare claims where:

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- The beneficiary presents (or has presented) some evidence of his/her coverage under a Medigap plan or eligibility for Medicaid benefits and a corresponding COBA ID for the identified Medigap insurer or State Medicaid Agency can be located on CMS' COBA claim-based ID listing;
- The provider or supplier participates in the Medicare Program. Note that this condition applies both to Medigap and Medicaid claim-based crossover; and
- The beneficiary assigns (or has assigned) his/her Medigap benefits to the provider or supplier.

Implementation

July 6, 2004

Because of this instruction's impact on providers and suppliers, Carriers and DMERCs will not be required to implement the COBA claim-based crossover requirements described in this instruction until October 4, 2004. Effective October 4, 2004, all participating Part B and DME providers and suppliers will cease including the Carrier or DMERC-issued Medigap or Medicaid ID on incoming claims. Instead, they will begin to include the claim-based COBA ID, which will be assigned by Medicare's Coordination of Benefits Contractor (COBC), on incoming claims. When Part B or DME providers or suppliers check the claim-based COBA ID listing and locate the beneficiary's identified Medigap plan, they shall include the Medigap claim-based COBA ID on the incoming claim if: 1) the provider or supplier participates in the Medicare Program; and 2) the beneficiary assigns (or has assigned) his/her rights to benefits to the provider or supplier. When Part B or DME providers or suppliers that participate in the Medicare Program check the claim-based COBA ID listing and locate the State Medicaid Agency that pays benefits for the beneficiary, they shall include the Medicaid claim-based COBA ID on the incoming claim.

As of October 4, 2004, CMS will require participating Part B and DME providers and suppliers to include the CMS-issued Medigap or Medicaid claim-based COBA ID on their submitted claims to Medicare if they wish to have their patients' Medicare claims crossed over to the Medigap or Medicaid insurer that does not supply an eligibility file for their insureds. (Section 70.6 of Chapter 28 of the Medicare Claims Processing Manual (Pub 100-04) has complete details concerning this requirement as well as other coordination of benefits procedures.)

Additional Information

You can find the Centers for Medicare & Medicaid Services (CMS) Program Manuals Index at the following CMS Web site:
www.cms.hhs.gov/manuals/cmsindex.asp

Also, the Medicare Claims Processing Manual (Pub 100-04) is located at the following CMS Web site:
www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Chapter 28 of that manual may be found at:
www.cms.hhs.gov/manuals/104_claims/clm104c28.pdf

Additional Coordination of Benefits information can be found at:
www.cms.hhs.gov/manuals/105_msp/msp105c04.pdf

The Consolidation of the Claims Crossover Process: Smaller-Scale Initial Implementation

Medlearn Matters Number: MM3218
Related Change Request (CR) #: 3218
Related CR Release Date: April 9, 2004
Related CR Transmittal #: 138
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

The following information affects all Medicare physicians, providers, and suppliers.

Provider Action Needed

In recent instructions to Medicare carriers, including Durable Medical Equipment Carriers (DMERCs) and Fiscal Intermediaries (FIs), the Centers for Medicare & Medicaid Services (CMS) presented the requirements for a redesigned process for coordination of benefits activities. (For an explanation of these requirements/instructions, see Medlearn Matters article MM3109.)

In CR 3218, CMS is advising the carriers, FIs, and DMERCs that the implementation schedule is being altered and some requirements have changed. Providers need to be aware of how these changes, as described below, may affect them.

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The key message is that the impact of this change on providers is delayed from July 6 until further notice.

Background

The Centers for Medicare & Medicaid Services (CMS) is starting the consolidation of the claims crossover process by beginning with a smaller-scale implementation on July 6, 2004. Through this instruction, CMS announces which portions of Transmittal R-98 (Change Request (CR) 3109) are:

- Still applicable;
- Which requirements have changed; and
- Which requirements are being moved to the October 4, 2004, systems release or to another future release.

Details regarding the requirements that have changed, and which are being moved to the October 4, 2004, systems release or to another future release, are listed in CR3218, which can be found at the CMS Web site address that is included in the Additional Information section of this article.

A key change is that the entire process will not be implemented on July 6, 2004, as mentioned in CR3109 and Medlearn Matters article MM3109.

Instead, a pilot test will be conducted from July 6, 2004, through October 1, 2004, when approximately eight Coordination of Benefits Agreement (COBA) trading partners will participate as beta-testers in a parallel production crossover environment.

During the parallel production period, the eight COBA trading partners will continue to receive crossover claims from Medicare contractors and will also receive crossover claims as part of the COBA process.

In light of CMS' decision to implement the COBA crossover consolidation project on a smaller scale within a parallel environment, Medicare carriers/FIs/DMERCs will continue to follow their current processes for the printing of Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) crossover messages throughout the period from July 6, 2004, to October 1, 2004.

Medicare contractors will also continue to charge all trading partners to whom they cross Medicare claims.

During the parallel production period, CMS' Medicare Coordination of Benefits Contractor (COBC) will **not** be charging the trading partners that participate in the COBA beta-site testing for claims that it crosses to them.

The eligibility-based crossover process will begin to be implemented on a larger scale on October 4, 2004. Also on October 4, 2004, the initial eight COBA beta-site testers will be converted to full production and will begin to be charged for claims that the COBC crosses over to them.

CMS' claim-based COBA crossover process is being delayed until a future systems release.

This process previously had a major impact on the provider community as of October 2004, and that will not occur in October 2004, as previously planned.

Implementation

The implementation date for this instruction is July 6, 2004. This means that only those participating in the pilot phase are affected on that date. All other trading partners will not be affected until October 1, 2004, at the earliest. Additional instructions will be issued as new implementation dates are established for moving from the pilot phase to full implementation.

Additional Information

The official instruction issued to your Medicare contractor regarding this change may be found by going to:
www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Also, Transmittal R-98, Change Request 3109, Consolidation of the Claims Crossover Process: Additional Common Working File (CWF) Functionality, dated February 6, 2004, can be found at the following CMS Web site:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3109.pdf

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Change Request 3218 supercedes CR 3109 and deletes the impact on provider requirements listed in requirements 20 and 21 in CR 3109. Consolidated claim-based crossovers have been delayed until further notice. The claim-based crossover process remains unchanged at the Medicare contractors.

New Part B Annual Deductible

Medlearn Matters Number: MM3121
Related Change Request (CR) #: 3121
Related CR Release Date: March 12, 2004
Related CR Transmittal #: 3
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects physicians, suppliers, and providers.

Provider Action Needed

Physicians, suppliers, and providers should note that, effective January 1, 2005, the Supplementary Medical Insurance (SMI) or Medicare Part B deductible will be $110. These providers should assure that their billing processes are adjusted to handle this change in the Medicare Part B deductible.

Background

Medicare Part B helps beneficiaries pay for physician's services, diagnostic tests, ambulance services, durable medical equipment, and other health services, and the beneficiary is responsible for the first $100.00 deductible of Medicare Part B approved charges each calendar year, i.e. their annual deductible. For calendar years 1991 through 2004, the Medicare Part B annual deductible has been $100.

Beginning in 2005, the Medicare Part B deductible will be $110 (based on Section 629 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA)).

Implementation

This change is effective on January 1, 2005, and the implementation date in Medicare claims processing systems will be January 3, 2005.

Related Instructions

The Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations), Section 20 (Supplementary Medical Insurance (SMI) (Part B), Subsection 20.2 (Part B Annual Deductible) has been revised and is included below with changes bolded and italicized.

20.2 - Part B Annual Deductible - (Rev.)
In each calendar year, a cash deductible must be satisfied before payment can be made under SMI. (See 20.4 of this chapter for exceptions.)

- ***For 2005, and until further notice, the deductible is $110.***
- ***From 1991 through 2004***, the deductible is $100.
- From 1982 through 1990, the deductible was $75.
- From 1973 through 1981, the deductible was $60.
- From 1966 through 1972, the deductible was $50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on Medicare allowed amounts. ***Non-covered*** expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received. Services that are not subject to the deductible cannot be used to satisfy the deductible.

Additional Information

You can find the Centers for Medicare & Medicaid Services (CMS) Program Manuals Index at the following CMS Web site:
www.cms.hhs.gov/manuals/cmsindex.asp

Also, the *Medicare General Information, Eligibility, and Entitlement Manual* is located at the following CMS Web site:
www.cms.hhs.gov/manuals/101_general/ge101index.asp

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EDI & HIPAA

Current information on HIPAA requirements and DMERC implementation instructions are available on the DMERC A Web site at:
www.umd.nycpic.com/emc&hipaa.html

Elimination of the 90-day Grace Period for HCPCS Codes

Medlearn Matters Number: MM3093
Related Change Request (CR) #: 3093
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R89CP
Effective Date: January 1, 2005
Implementation Date for Medicare Systems: July 6, 2004

The following information affects all physicians, providers, and suppliers who use Healthcare Common Procedure Coding System (HCPCS) codes in billing Medicare Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs).

Provider Action Needed

Impact to You - Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period to use discontinued HCPCS codes for services rendered in the first 90 days of the year. Use of such codes to bill services provided after the date on which the codes are discontinued will cause your claims to be returned and not paid. **In essence, HCPCS codes must be valid at the time the service is rendered.**

What You Need to Know - Providers should be aware that **effective January 1, 2005**, carriers, DMERCs, and FIs will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1.

What You Need to Do - To ensure prompt and timely payment of claims, use the new HCPCS for 2005 beginning with services rendered on or after January 1, 2005, and stop using discontinued codes at that time. Each year thereafter, be sure to adopt the new codes.

Background

The Healthcare Common Procedure Coding System (HCPCS) consists of the following two levels of codes:

- Level I codes that are copyrighted by the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4); and
- Level II codes that are five-position, alpha-numeric codes approved and maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare & Medicaid Services (CMS), the Health Insurance Association of America, and the Blue Cross and Blue Shield Association). The D code series in Level II HCPCS is copyrighted by the American Dental Association.

Medicare has permitted a 90-day grace period after implementation of an updated HCPCS code set to familiarize providers with the new codes and to learn about the discontinued codes. For example, the 2004 HCPCS codes became effective for dates of service on or after January 1, 2004, and Medicare contractors are able to apply a three-month grace period for all applicable discontinued HCPCS codes. This means that the 2003 discontinued HCPCS codes and the new 2004 HCPCS codes will be accepted by carriers from physicians, suppliers, and providers during the January 2004-March 2004 grace period. This 90-day grace period applies to claims received by the carrier prior to April 1, 2004, which contain the 2003 discontinued codes for dates of service January 1, 2004, through March 31, 2004.

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires providers to **use the medical code set that is valid at the time that the service is provided**.

Therefore CMS will no longer be able to allow a 90-day grace period for providers to learn about the discontinued HCPCS codes. Providers should be aware that effective January 1, 2005, carriers, DMERCs, and fiscal intermediaries will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1. In addition, effective January 1, 2005, CMS will no longer allow a 90-day grace period for discontinued codes resulting from any mid-year HCPCS updates.

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In order for providers to know about the new, revised, and discontinued numeric CPT-4 codes for the upcoming year, they should obtain the American Medical Association's CPT-4 coding book that is published each October. CMS posts on its Web site the annual alpha-numeric HCPCS file for the upcoming year. The CMS Web site to view the annual HCPCS update is
www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp

Physicians, providers, and suppliers should be aware that Medicare systems will begin to reject such discontinued codes, beginning on January 1, 2005, if the codes were not effective on the date of service. Such claims will be returned to the submitter for correction.

This is a HIPAA-compliancy issue.

Implementation

July 6, 2004. While this is the date on which Medicare's claims processing systems will be changed to enforce these new rules, the systems will not apply these rules until January 1, 2005.

Related Instructions

The Medicare Claims Processing Manual (Pub. 100-4), Chapter 23, Section 20 (Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)), Subsection 20.4 (Deleted HCPCS Codes/Modifiers) was revised and is included below (changes bolded and italicized). Also, **sentences that referred to the three month HCPCS grace period** have been deleted from Subsections 40.1 (Access to Clinical Diagnostic Lab Fee Schedule Files) and 50 (Fee Schedules Used by All Intermediaries and Regional Home Health Intermediaries (RHHIs)).

20.4 – Deleted HCPCS Codes/Modifiers
(Rev.1, 10-01-03)
B3-4509.3, HO-442.2
Claims for services in a prior year are reported and processed using the HCPCS codes/modifiers in effect during that year. For example, a claim for a service furnished in November 2002 but received by a carrier/DMERC/intermediary in 2003 should contain codes/modifiers valid in 2002 and is processed using the prior year's pricing files.

HCPCS codes (Level I CPT-4 and Level II alpha-numeric) are updated on an annual basis. Each October, CMS releases the annual HCPCS file to carriers/DMERCs/FIs. The HCPCS file contains the CPT-4 and the alpha-numeric updates. Contractors are notified of the release date via a one-time notification instruction. The file contains new, deleted, and revised HCPCS codes which are effective on January 1 of each year. With each annual HCPCS update, CMS has permitted a 90-day grace period for billing discontinued HCPCS codes for dates of service January 1 through March 31 that were submitted to Medicare contractors by April 1 of the current year.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical codes sets must be date of service compliant. Since HCPCS is a medical code set, effective January 1, 2005, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued HCPCS codes. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. Any codes discontinued mid-year will no longer have a 90-day grace period.

Contractors must eliminate the 90-day grace period from their system effective with the January 1, 2005, HCPCS update. Contractors will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31. Providers can purchase the American Medical Association's CPT-4 coding book that is published each October that contains new, revised, and discontinued CPT-4 codes for the upcoming year. In addition, CMS posts on its Web site the annual alpha-numeric HCPCS file for the upcoming year at the end of each October. Providers are encouraged to access CMS Web site to see the new, revised, and discontinued alpha-numeric codes for the upcoming year. The CMS Web site to view the annual HCPCS update is http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp

Carriers and DMERCs must continue to reject services submitted with discontinued HCPCS codes. FIs must continue to return to the provider (RTP) claims containing deleted codes.

See the Medicare Claims Processing Manual (Pub. 100-4), Chapter 22, "Remittance Notices to Providers."

For more information on HCPCS, visit the CMS Web site at:***www.cms.hhs.gov/medicare/hcpcs***

For more information on HIPAA and its impact on claims submission, please visit the CMS HIPAA Web site at: ***www.cms.hhs.gov/hipaa/hipaa2/default.asp***

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Elimination of the 90-day Grace Period for Billing Discontinued ICD-9-CM Codes

Medlearn Matters Number: MM3094
Related Change Request (CR) #: 3094
Related CR Release Date: February 6, 2004
Effective Date: October 1, 2004
Implementation Date: October 1, 2004

The following information affects all physicians, practitioners, and suppliers who use International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes in billing Medicare carriers and Durable Medical Equipment Regional Carriers (DMERCs).

Provider Action Needed

Impact to You - Medicare systems will begin enforcing the Health Insurance Portability and Accountability Act (HIPAA) standards on October 1, 2004, requiring that ICD-9-CM codes submitted on claims must be valid at the time the service is provided.

What You Need to Know - Physicians, practitioners, and suppliers should be aware that the Centers for Medicare & Medicaid Services (CMS) is instructing carriers and DMERCs to eliminate the 90-day grace period for billing discontinued ICD-9-CM diagnosis codes effective October 1, 2004.

What You Need to Do - Adopt the new codes in your billing processes effective October 1 of each year and begin using them for services rendered on or after that time to assure prompt and accurate payment of your claim.

Background

Medicare has previously permitted a 90-day grace period after the annual October 1 implementation of an updated version of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. This grace period gave physicians, practitioners, and suppliers time to become familiar with the new codes and learn about the discontinued codes.

During this 90-day grace period (October 1 through December 31 of each year), physicians, practitioners, and suppliers could use either the previous or the new ICD-9-CM diagnosis codes. For claims received on or after January 1, the updated ICD-9-CM codes were required to be used, and claims received with discontinued diagnosis codes were rejected as Returned Unprocessable Claims (RUCs).

However, the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Rule requires the use of national/medical code sets that are valid at the time that the service is provided, and ICD-9-CM is a national/medical code set.

Therefore, the Centers for Medicare & Medicaid Services (CMS) **can no longer allow a 90-day grace period** for physicians, practitioners, and suppliers to learn about the discontinued ICD-9 codes.

Providers can view the new, revised, and discontinued ICD-9-CM diagnosis codes at ***www.cms.hhs.gov/medlearn/icd9code.asp***. CMS updates this site annually after the updated diagnosis codes are published in the Federal Register, which usually occurs by May 1 of each year.

Effective for dates of service on and after October 1, 2004, no further 90-day grace periods will apply for the annual ICD-9-CM updates. Physicians, practitioners, and suppliers must bill using the diagnosis code that is valid for that date of service. Carriers and DMERCs will no longer be able to accept discontinued codes for dates of service after the date on which the code is discontinued.

This is a HIPAA-compliancy issue.

Implementation

October 1, 2004. This is the date on which Medicare's claims processing systems will be changed.

Related Instructions

The Medicare Claims Processing Manual (Pub. 100-4), Chapter 23, Section 10, Subsection 10.2 (Relationship of ICD-9-CM Codes and Date of Service) has been revised. The relevant revisions to Subsection 10.2 are the following:

10-2 – Relationship of ICD-9-CM Codes and Date of Service

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(Rev. 1, 10-01-03)
PM B-02-027 (CR-2108), B-03-063, B-02-064, B-03-002

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. Since ICD-9-CM is a medical code set, effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems in Table 6 and effective each October 1.

Carriers and DMERCs must eliminate the ICD-9-CM diagnosis code grace period from their system effective with the October 1, 2004 update. Carriers and DMERCs will no longer accept discontinued diagnosis codes for dates of service October 1 through December 31 of the current year. Claims containing a discontinued ICD-9-CM diagnosis code will be returned as unprocessable. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004. After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Web site: www.cms.hhs.gov/medlearn/icd9code.asp

For more information about the relationship of ICD-9-CM diagnosis codes and dates of service, go to Chapter 23, available at:
www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf

To view the actual instruction issued by CMS to your Medicare carrier, please go to:
www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf

For more information on HIPAA's rules that relate to claims submission, other transactions, and code sets, please visit: ***www.cms.hhs.gov/hipaa/hipaa2/default.asp***

Conversion of Electronic Submitters

Through vigorous educational efforts and coordinated partnerships, the Region A Durable Medical Equipment Regional Carrier (DMERC A) has maintained a position in the top ten of the Centers for Medicare & Medicaid Services (CMS) contractors relative to testing and conversion of electronic submitters and placed first among the four DMERC contractors. At the end of Fiscal Year 2003, approximately 58 percent of DMERC A electronic claims were submitted using the American National Standards Institute (ANSI) X12N 837 4010A transaction standards. As of March 2004, these percentages had risen to 83 percent for DMERC A.

Other ANSI standards being supported are the Health Insurance Portability and Accountability Act (HIPAA) compliant Eligibility Inquiry & Response, Claims Status Inquiry & Response, Electronic Remittance Advice, and Outbound (Coordination of Benefits) Claims. DMERC A is also required to support inbound and outbound National Council for Prescription Drug Programs (NCPDP) transactions for drug claims submitted by retail pharmacies.

Aggressive outreach efforts are now in progress to facilitate transition of the remaining submitters who use legacy transaction formats to the HIPAA transactions. If you are submitting your claims electronically and have not made the conversion to the new ANSI format, you will be contacted by the Electronic Data Interchange (EDI) Department in the near future.

For more information on how submission of non-HIPAA electronic claims can effect payments, please refer to the following *Medlearn Matters* article, "Modification of CMS' Medicare Contingency Plan for HIPAA Implementation." This article is also available on the CMS Web site at
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/mm2981.pdf

Modification of CMS' Medicare Contingency Plan for HIPAA Implementation

Medlearn Matters Number: MM2981
Related Change Request (CR) #: 2981
Related CR Release Date: February 27, 2004
Related CR Transmittal #: 114
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

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The following information affects all Medicare physicians, providers, and suppliers who submit electronic claims to Medicare.

Provider Action Needed

Impact to You - Effective July 1, 2004, Medicare is modifying its Health Insurance Portability and Accountability Act (HIPAA) contingency plan. The modification continues to allow submission of non-compliant electronic claims. However, the payment of electronic claims that are **not** HIPAA-compliant will take thirteen (13) additional days.

What You Need to Know - While the contingency plan remains in place, the submission of non-HIPAA electronic claims to Medicare after July 6, 2004, means that Medicare will take longer to pay such claims.

What You Need to Do - Submit HIPAA-compliant claims. If you are already submitting HIPAA-compliant claims or will do so on or before July 6, 2004, then this change does not apply to you.

Background

Currently, Medicare pays electronic media claims (EMC) no earlier than the 14th day after the date of receipt (13-day waiting period). Non-electronic claims cannot be paid earlier than the 27th day after the date of receipt (26-day waiting period).

HIPAA requires that claims submitted electronically, effective October 16, 2003, be in a format that complies with the appropriate standard adopted for national use.

The Administrative Simplification and Compliance Act (ASCA) requires claims to be submitted to Medicare electronically, with some exceptions, effective October 16, 2003.

Based on guidance issued by the Department of Health and Human Services to maintain cash flow in the health care industry beyond October 16, 2003, and the fact that only 33 percent of Medicare's electronic claims were in HIPAA formats as of that date, Medicare implemented a contingency plan to temporarily allow electronic claims to continue to be submitted in a pre-HIPAA format. This was done to provide those members of the healthcare community, who demonstrate a good faith effort to comply, additional time to become HIPAA-compliant.

Under the subject modification to the October 16, 2003, contingency plan, those claims submitted electronically **and** in a HIPAA-compliant format will continue to be considered as eligible for Medicare payment on the 14th day after the date of receipt. Claims submitted electronically in a pre-HIPAA format under a Medicare contingency plan, will be considered as eligible for Medicare payment on the 27th day after the date of receipt. **As an example, HIPAA-compliant claims received on July 1, 2004, can be paid as early as July 15, while a claim that is not HIPAA-compliant and is received electronically on July 1, 2004, can be paid no earlier than July 28.**

Medicare is continuing to allow claims to be submitted in a pre-HIPAA format for a limited time to maintain provider payments, but this modification of the contingency plan should provide an incentive for moving to HIPAA formats quickly. This is a measured step toward ending the contingency plan for all incoming claims.

Important Dates

Medicare has instructed its carriers and intermediaries to begin enforcing these rules on July 6, 2004, and the rules will apply to claims received on or after July 1, 2004.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) has instructed its Medicare carriers and intermediaries to make available free/low cost software that will enable submission of HIPAA-compliant claims electronically. Contact your carrier or intermediary in order to obtain this software at their special electronic data interchange (EDI) number. For those billing Medicare Part A (including hospital outpatient services), a list of these numbers by State is available at: ***www.cms.hhs.gov/providers/edi/anum.asp***

For those billing Medicare Part B, you may find those numbers listed by state at: ***www.cms.hhs.gov/providers/edi/bnum.asp***

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For additional information on HIPAA, visit the CMS Web site at: ***www.cms.hhs.gov/hipaa/hipaa2/default.asp***

To view the revised manual chapter for the claims receipt rules, see Chapter 1, Section 80.2.1.2, which can be found in Pub 100-04, Medicare Claims Processing Manual. This can be found at: ***www.cms.hhs.gov/manuals/104_claims/clm104index.asp***

To view the actual instruction issued by CMS to your carrier or intermediary, visit: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. Once at that site, scroll down the CR NUM column to 2981 and click on that file.

Medicare Providers: Their Vendors, Clearinghouses, or Other Third-Party Billers and the HIPAA/Medicare Contingency Plan

Medlearn Matters Number: SE0414
Related Change Request (CR) #: N/A
Effective Date: N/A - Informational Only

The following information affects all Medicare physicians, providers, and suppliers who use a vendor, clearinghouse, or other third-party billing agent to submit Medicare claims.

Provider Action Needed

Understand the requirements of HIPAA, the Medicare HIPAA contingency plan, its impact, and the need to verify HIPAA compliance by those who bill Medicare on your behalf.

Background

In a recent Medlearn Matters article (see MM2981, which may be found at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf***), the Centers for Medicare & Medicaid Services (CMS) announced a modification of the HIPAA contingency plan implemented by Medicare on October 16, 2003. Specifically, CMS announced on February 27, 2004, that Medicare would continue to accept claims electronically in a pre-HIPAA format on or after July 1, 2004, but such claims would not be eligible for Medicare payment until the 27th day after receipt, at the earliest. All electronic claims today are eligible for payment at 14 days after receipt.

This modification of the HIPAA contingency plan was intended to give providers additional time to become HIPAA compliant, but **was also a measured step toward ending the contingency plan for all incoming Medicare claims**.

CMS understands that many physicians, providers, and suppliers do not submit claims directly to Medicare, but submit their claims through a third party, such as a billing vendor, clearinghouse or other third-party billing agent. CMS recognizes the importance of these third parties to many providers and the extent to which providers rely on those entities to meet HIPAA requirements in a cost-effective manner with minimal impact on the provider's most important mission, i.e., delivering high quality medical care to those who need such care.

Each provider has made a business decision to use these agents and is therefore best positioned to assess the value of that decision.

CMS urges Medicare providers to understand the following issues, to assess their impact on the provider's business and determine what, if any, steps need to be taken.

Issue # 1 - Understand where your vendor, clearinghouse, or other third party biller stands in terms of HIPAA compliance.
Providers are required by statute to achieve compliance and to bill Medicare electronically in a HIPAA compliant manner. Thus, it is crucial for providers to assure themselves of their third-party partner's readiness. It is especially important to remember that, at the time Medicare's contingency plan is terminated, providers who remain non-compliant will face significant problems.

So, what steps might providers take to assure that they AND their partners are ready?

- Check with your clearinghouse, vendor, or other third party biller.
- Ask them about their readiness.

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- Ask them how they have determined their readiness.
- Make sure they are aware of the Medicare contingency plan and the modification announced on February 27th.
- Ask them if your claims will continue to be eligible for payment on the 14th day after receipt, as of July 1, 2004. Or, will your claims not qualify for such prompt payment from Medicare?
- If your agent indicates that the Medicare contingency plan will affect your claims, ask them when they will correct the problem so your claims are eligible for prompt payment and ask when that will happen.

As stated earlier, CMS's business relationship is with providers and we look to the provider to meet requirements for correct submission of claims in HIPAA compliant formats. We also know that every piece of the process, and every entity involved, must be ready. That is why it is important for providers to question their agents, obtain assurances, and keep abreast of HIPAA developments. Ultimately, the benefits of compliance or the consequences of non-compliance will fall on the provider. Remember that continued timely payment of Medicare claims is closely linked to HIPAA readiness.

Issue #2 - Make sure your agent builds on the HIPAA compliance you have achieved.
There have been instances where some third-party billers are taking claims submitted to them by Medicare providers that are HIPAA compliant and then converting them to a non-compliant format before sending them to a Medicare claims processing contractor. Such vendors and agents may be doing this because some of their providers are still not HIPAA compliant and the vendor has chosen to submit non-compliant formats for all their provider customers until all customers are compliant.

These decisions may make good business sense to the vendor, clearinghouse or other third party biller, but their decision may adversely affect providers who are compliant. That will certainly be the case for such claims submitted to Medicare on or after July 1, 2004, when Medicare deems such claims do not qualify for the prompt payment afforded to electronic claims that are HIPAA compliant. At the time Medicare ends its contingency plan, the consequences for non-compliant claims could be even more severe, e.g., a complete stoppage of payments for such claims.

What can providers do? The answer is similar to the one presented for the first issue, i.e., talk with your vendor, clearinghouse, or other third party biller. Ask them about their readiness. Ask them if they are altering your HIPAA compliant input to them into a non-compliant format before sending to Medicare. Ask them to assure you that your claims will remain eligible for payment on the 14th day after receipt on and after July 1, 2004.

As mentioned before, it is the provider's ultimate responsibility to assure they are HIPAA compliant and that means assuring that your claims meet the transaction code set and format standards.

Issue # 3 - Understand when your vendor, clearinghouse, or other third party biller will stop accepting non-compliant transactions.
While CMS implemented a contingency plan on October 16, 2003, which allows Medicare providers, suppliers, and other electronic billers to continue sending pre-HIPAA formats, that plan is not binding on other entities. At any time, vendors, clearinghouses, and other third party billers could decide to limit or discontinue supporting pre-HIPAA formats.

We encourage providers and suppliers using a third party entity for sending their electronic claims to work closely with that entity to understand the HIPAA electronic claims requirements. Verify that you are submitting the data required under HIPAA and that your claims are being transmitted in the standard HIPAA format.

In conclusion, the bottom line is that, in order to protect your interests and ensure **uninterrupted cash flow**, begin immediately to work toward meeting the HIPAA standard requirements.

Additional Information

For additional information on HIPAA, visit the CMS Web site at: ***www.cms.hhs.gov/hipaa/hipaa2/default.asp***

Update to the Healthcare Provider Taxonomy Codes (HPTCs) Version 4.0

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Medlearn Matters Number: MM3188
Related Change Request (CR) #: 3188
Related CR Release Date: April 16, 2004
Related CR Transmittal #: 71
Effective Date: May 17, 2004
Implementation Date: May 17, 2004

The following information affects physicians, suppliers, and providers who bill carriers and Durable Medical Equipment Carriers (DMERCs).

Provider Action Needed

Affected providers should note that Medicare Contractors (Carriers and DMERCs) must obtain the Health Care Provider Taxonomy Code (HPTC) list, Version 4.0, and use it to validate HPTCs in claims for services on or after May 17, 2004.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable the electronic exchange of health information. Since the Health Care Provider Taxonomy Code is a named code set in the 837 Professional Implementation Guide, contractors must validate the inbound taxonomy codes against their internal HPTC tables.

The summary of changes for the Health Care Provider Taxonomy Code list, Version 4.0, is as follows:

Provider Taxonomy Value	Revision
208VP0000X	Modified title from *Pain Management* to *Pain Medicine* and added definition
106H00000X	Modified definition
207VM0101X	Added definition

Implementation

The implementation date for this instruction is May 17, 2004, when Version 4.0 of this code set will be used by carriers and DMERCs for claims with dates of service on or after May 17, 2004.

Additional Information

The official instruction issued to your carrier/DMERC regarding this change may be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc_asp***

From that web page, look for CR3188 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Health Insurance Portability and Accountability Act (HIPAA) X12N 837 Professional Health Care Claim Implementation Guide (IG) Editing

Medlearn Matters Number: MM3050
Related Change Request (CR) #: 3050
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R86CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

The following information affects physicians, practitioners, suppliers, and providers who bill Medicare carriers, including Durable Medical Equipment Carriers (DMERCs).

Provider Action Needed

Impact to You - Affected providers should stop submitting electronic claims with diagnosis codes, zip codes, or telephone numbers that are not HIPAA-compliant.

What You Need to Know - Providers should note that Medicare systems are strengthening their system edits to assure receipt of HIPAA-compliant claims. Effective July 1, 2004, Medicare will reject electronic claims that have diagnosis codes, zip codes, or telephone numbers that are not HIPAA-compliant.

What You Need to Do - Be sure your billing systems are modified to generate electronic claims that will pass Medicare's HIPAA-compliancy edits for diagnosis codes, zip codes, and telephone numbers.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable health information

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to be exchanged electronically. In addition, one of the HIPAA provisions requires standard formats to be used for electronically submitted health care transactions.

The Centers for Medicare & Medicaid Services (CMS) is committed to implementing the 837 coordination of benefits (COB) transaction set per the HIPAA implementation guide (IG), and it recognizes that a change in its systems is needed to:

1. Comply with the 837 Professional IG; and
2. To allow the creation of compliant COB claim files. To accomplish this, Medicare systems will be changed to include edits that reject electronic claims that contain:
   - Invalid diagnosis codes;
   - A dash, space, or special character in any zip code field; and
   - A dash, space, special character, or parenthesis in telephone numbers.

Implementation

July 6, 2004

Related Instructions

The ANSI X12N 837 implementation guides are the standards of compliance for claim transactions and are available electronically at:
www.wpc-edi.com/hipaa/HIPAA_40.asp

The Medicare Claims Processing Manual (Pub. 100-4), Chapter 24 has been updated to include the new Section 40.7.2, Professional Implementation Guide (IG) Edits. This new section is included below:

40.7.2 – X12N 837 Professional Implementation Guide (IG) Edits

The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain invalid diagnosis codes whether pointed to or not.

The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain a dash, space, or special character in any zip code.

The Part B Carriers and Durable Medical Equipment Regional Contractors (DMERCs) must reject inbound electronic claims that contain dashes, spaces, special characters or parentheses in any telephone number.

Additional Guidelines for Implementing the National Council for Prescription Drug Program (NCPDP) Standards under HIPAA

Medlearn Matters Number: MM3095
Related Change Request (CR) #: 3095
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R84CP
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

The following information affects durable medical equipment (DME) suppliers.

Provider Action Needed

Impact to You - According to the Health Insurance Portability and Accountability Act (HIPAA) implementation guide (IG), Medicare systems must be able to receive the NCPDP HIPAA claim transaction with segments in any order.

What You Need to Know - According to the NCPDP standards, "The receiver cannot force an order of the segments." DME regional carriers (DMERCs) systems then must allow segments to be transmitted in any order, as long as the group separator precedes any of the segments.

What You Need to Do - Effective July 1, 2004, the Medicare DMERCs will change their systems to allow segments to be transmitted in any order. In addition, the Medicare systems will be changed effective July 1, 2004, to allow the "MOD" value on certain segments. Be aware of these changes as HIPAA compliancy moves forward.

Background

Effective July 1, 2004, Medicare claims systems used by DMERCs will allow segments to be submitted in any order including the AM07, AM03, and AM11, in accordance with the NCPDP standard. In addition, the DMERCs must allow the value of "MOD" to be entered in positions 001-003 of the narrative portion of the prior authorization segment indicating the supporting documentation that follows is Medicare modifier information.

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Additional Information

Should you have any questions regarding these changes or encounter any problems with claims that follow the NCPDP rules as described above after July 1, 2004, please contact your DMERC at their toll-free number. If you do not know that number, you may find it at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Processing National Drug Code (NDC) Numbers

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), Durable Medical Equipment Regional Carriers (DMERCs) now receive many NDCs for drugs. In order to process these claims, the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) will provide the DMERCs, and their system maintainers, a new update of the NDC crosswalk file in April and monthly thereafter. Therefore, NDC codes that have been deactivated/end dated on the NDC crosswalk shall be rejected beginning in April 2004.

If a code has been deactivated, **even for a short time**, the claim line will be rejected if the date of service is during the time the code is deactivated/end dated. DMERCs shall use the following revised/new remit message with rejections:

> **M119** - Missing/incomplete/invalid/deactivated or withdrawn National Drug Code (NDC).

The NDC crosswalk is available via SADMERC's Web site at:
www.palmettogba.com/palmetto/Other.nsf/$$ViewTemplate+for+Docs?ReadForm&Other+Medicare+Partners/SADMERC/NDC+Crosswalk

[Reference: Change Request (CR) 3141, Transmittal 104]

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Per the Health Insurance Portability and Accountability Act (HIPAA) of 1996, health plans must be able to conduct standard electronic transactions for transactions mentioned in the regulation. The version 4010A1 of X12N transactions, as presented in the X12N Implementation Guides (IGs), have been adopted as the standard transactions. Medicare policy is to follow the IGs to be HIPAA-compliant. For transaction 835 (Health Care Claim Payment/Advice), there are two code sets – reason and remark code sets – that must be used, and these code sets are updated on a regular basis.

X12N 835 Health Care Remittance Advice Remark Codes

The complete list of remark codes is available at ***www.wpc-edi.com/Codes.asp*** and ***www.cms.hhs.gov/providers/edi/hipaadoc.asp***. The following list summarizes changes made from July 1, 2003, to October 31, 2003.

Code	Current Narrative
N212	Changes processed under a Point of Service benefit.

Modified Remark Codes:

Code	(Modification Date) - Current Modified Narrative
M39	(Modified 10/31/03) - The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.
M68	(Modified 2/28/03, 10/31/03) - Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
M80	(Modified 10/31/03) - Not covered when performed during the same session/date as a previously processed service for the patient.
M81	(Modified 10/31/03. See M76 for rest of the previous text) - You are required to code to the highest level of specificity.
M84	(Modified 10/31/03) - Medical code sets used must be the codes in effect at the time of service
M116	(Modified 10/31/03) - Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project.
MA76	(Modified 2/28/03, 10/31/03) - Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
MA121	(Modified 2/28/03, 6/30/03, 10/31/03) - Missing/incomplete/invalid date the x-ray was performed.
N40	(Modified 2/28/03, 6/30/03, 10/31/03) - Missing/incomplete/invalid x-ray.

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Code	(Modification Date) - Current Modified Narrative
N157	(New Code 2/28/03; Modified 10/31/03) - Transportation to/from this destination is not covered.
N160	(New Code 2/28/03; Modified 10/31/03) - The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.

Deactivated Remark Codes:

Code	(Deactivation Date) - Current Modified Narrative
M33	(Modified 2/28/03; Deactivated eff. 8/1/04. Refer to M68) - Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
M34	(Deactivated eff. 8/1/04. Refer to MA120) - Claim lacks the CLIA certification number.
M88	(Deactivated eff.8/1/04. Refer to Reason Code B20) - We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M92	(Deactivated eff. 8/1/04) - Services subjected to review under the Home Health Medical Review Initiative.
MA06	(Modified 2/28/03; Deactivated eff. 8/1/04. Refer to MA31) - Missing/incomplete/invalid beginning and/or ending date(s).
MA49	(Modified 2/28/03; Deactivated eff.8/1/04. Refer to MA76) - Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.
MA85	(Deactivated eff. 8/1/04. Refer to MA92) - Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
MA86	(Modified 2/28/03; Deactivated eff. 8/1/04. Refer to MA92) - Missing/incomplete/invalid group or policy number of the insured for the primary coverage.
MA87	(Modified 2/28/03; Deactivated eff.8/1/04. Refer to MA92) - Missing/incomplete/invalid insured's name for the primary payer.
MA102	(Modified 2/28/03; Deactivated eff. 8/1/04. Refer to M68) - Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.
N17	(Deactivated eff. 8/1/04. Refer to Reason code 1) - Per admission deductible.

X12 N 835 Health Care Claim Adjustment Reason Codes

The updated list is posted at ***www.wpc-edi.com/codes/Codes.asp*** (select Claim Adjustment Reason Codes from the pull down menu). All reason code changes approved in September 2003 are listed here.

Reason Code Changes (as of 10/31/03):

Code	(Notes) - Current Narrative
156	(New as of 9/03) - Flexible spending account payments.
157	(New as of 9/03) - Payment denied/reduced because service/procedure was provided as a result of an act of war.
158	(New as of 9/03) - Payment denied/reduced because service/procedure was provided outside of the United States.
159	(New as of 9/03) - Payment denied/reduced because service/procedure was provided as a result of terrorism.
160	(New as of 9/03) - Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.
113	(Inactive for version 4060. Use codes 15, 158 or 159) - Payment denied/reduced because service/procedure was provided outside the United States or as a result of war.
A2	(Inactive for version 4060. Use code 45 with Group Code "CO" or use another appropriate specific adjustment code.) - Contractual Adjustment

Effective April 1, 2004, the above coding changes are applicable for Medicare remittance advices.

[Reference: Change Request (CR) 3122; Transmittal 93]

Update Your EDI Information

If you are using a software vendor that has successfully passed testing with the American National Standards Institute (ANSI) 837 transaction with the Region A Durable Medical Equipment Regional Carrier (DMERC A), you are required to move your workload into the ANSI format immediately. If you are not sure if your vendor has successfully passed testing, view the list on our Web site at: ***www.umd.nycpic.com/ANSI_listing.html***

If you have switched to a billing service and are no longer billing for yourself or using a software vendor, please contact the DMERC A Electronic Data Interchange (EDI) Department immediately and we will remove you from our National Standard Format (NSF) mailing listing. You may reach EDI via phone at 866-861-7348 or via email at: ***team.edi@healthnow.org***.

Note: See the EDI ListServe artcle on page 29.

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Miscellaneous

Reminder: DMERC A P.O. Boxes

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

The Comprehensive Error Rate Testing (CERT) Process

The Centers for Medicare & Medicaid Services (CMS) developed the CERT program to produce national, contractor's specific, and service-specific paid claim error rates. The program has independent reviewers periodically review representative random samples of Medicare claims that are identified as soon as they are accepted into the claims processing system at Medicare contractors. The independent reviewers medically review claims that are paid and claims that are denied to ensure that the decision was appropriate.

It is important for providers to respond to CERT contractors' requests for medical records and to answer/direct questions to the proper representative. For more information, please refer to the article "Supplier Response to Comprehensive Error Rate Testing (CERT)" under the Additional March 2004 Bulletins listed on the "What's New" page of the Region A Program Safeguard Contractor Web site at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

[Reference: Change Request (CR) 2976; Transmittal 67]

Fee Schedule Updates

The 2004 fee schedule for parenteral and enteral nutrition (PEN) is available via the "Fee Schedules" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site (***www.umd.nycpic.com/ dmfees.html***). In addition to the PEN fees, the following updates can be accessed via the "2004 Fee Schedule Article/Information" link. (*Note*: Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.)

Correction to Fee Schedule - Prosthetics & Orthotics

The previously published 2004 fee schedule for prosthetics and orthotics contains two listings for Healthcare Common Procedure Coding System (HCPCS) code V2118. The first listing is the correct fee schedule amounts for V2118. The second listing is for HCPCS code V2121, however, some of the listed fees are incorrect. The correct fee schedule amounts for V2121 are listed below and are effective April 1, 2004.

Ceiling	CT	DE	MA	ME	NH
$80.96	$68.44	$63.45	$68.44	$68.44	$68.44
Floor	**NJ**	**NY**	**PA**	**RI**	**VT**
$60.72	$67.62	$67.62	$63.45	$68.44	$68.44

J1563 Fee Revision

Effective April 1, 2004, there has been a fee revision for the code listed below:

Code	Description	Fee
J1563	Injection, immune globulin, intravenous 1G	$66.00

Therapeutic Shoes - K0628 and K0629

Effective for dates of service on or after April 1, 2004, the following new Healthcare Common Procedure Coding System (HCPCS) codes will be added:

K0628 For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer of 3/16 inch material of shore a 40 (or higher), prefabricated, each

K0629 For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material, custom fabricated, each

The HCPCS codes K0628 and K0629 will replace A5509 and A5511 respectively. Under the standard grace period, deleted codes A5509 and A5511 will continue to be accepted with dates of service on or

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after April 1, 2004, that are received prior to July 1, 2004. Claims billed with dates of service on or after April 1, 2004, that DMERC A receives on or after July 1, 2004, will be denied as unprocessable or as being incorrectly coded. The DMERCs shall apply the 2004 customary, prevailing, and inflation-indexed charges for codes A5509 and A5511 to newly established codes K0628 and K0629, respectively.

Drug Fees: J1563 and J1564

Effective April 1, 2004, the following fees have been established for the two codes listed below.

Code	Description	Fee
J1563	Injection, immune globulin, intravenous, 1G	$46.48
J1564	Injection, immune globulin, 10MG	$0.82

Correction to L5679 Fees

The previously published 2004 fee schedule contains incorrect fees for several states listed under procedure code L5679. The following are the correct fees for this code (corrected fees are indicated in **bold**), which are effective January 1, 2004.

CT	DE	MA	ME	NH
$527.21	**$469.51**	$527.21	$527.21	$527.21

NJ	NY	PA	RI	VT
$446.56	$446.56	**$469.51**	**$527.21**	**$527.21**

[References: Change Request (CR) 2957, Transmittal 17; CR 3014, Transmittal 58; CR 3024, Transmittal 62; CR 3029, Transmittal 44; CR 3059, Transmittal 6; CR 3060, Transmittal 74]

MMA - New Medicare-Approved Drug Discount Cards and Transitional Assistance Programs

Information is available for physicians and other health care professionals via the Centers for Medicare & Medicaid Services Web site at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0422.pdf***, and for pharmacists and other pharmacy professionals at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0423.pdf***

For download informational materials and further information on other MMA provisions, visit: ***www.cms.hhs.gov/medlearn/drugcard.asp***

Implementation of New Medicare Redetermination Notice

Medlearn Matters Number: MM2620
Related Change Request (CR) #: 2620
Related CR Release Date: February 6, 2004
Related CR Transmittal #: R97CP
Effective Date: October 1, 2004
Implementation Date: July 6, 2004

The following information affects all Medicare physicians, providers, and suppliers.

Provider Action Needed

Impact to You - The first level of appeal for fee-for-service has a new name. Starting in October, first level appeals will be called "Redeterminations." You and your patients will receive a formal decision notification letter—the Medicare Redetermination Notice (MRN)—for any decision made on a request for redetermination made on or after October 1, 2004.

What You Need to Know - Contractors who judge these redetermination appeals must make their decisions within 60 days as a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and must then notify the providers and beneficiaries involved via the Medicare Redetermination Notice (MRN) (unless the decision is to pay the claim). The MRN describes the redetermination process, explains the results of the Medicare appeal, and provides information about how to file an appeal regarding Medicare's decision.

What You Need to Do - The newly initiated Redetermination Appeals Process provides information in a more concise and understandable manner and has been well received by Medicare beneficiaries and providers in consumer testing. The Appeals Process provides for timely notification of beneficiaries and providers via the (MRN). Be sure to understand how these new procedures affect your appeal rights.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, Section 521). Section 1869 (a)(3)(C)(ii) required contractors to mail a written notification of the redetermination decision to the parties of an appeal.

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This section was then amended by MMA [Sections 1869 (a)(5) and 1869 (a)(4)(B)] to include specific requirements for the notices themselves. The requirements ensure that claim appellants receive complete, accurate, and understandable information about their redetermination decisions, as well as information explaining the process of further appeals.

The Centers for Medicare & Medicaid Services (CMS) has provided a model cover letter and a Medicare Redetermination Notice to serve as guidelines for Medicare carriers and intermediaries who make the redeterminations. The MMA also ensures that redetermination decisions are made in a timely manner by requiring that 100% of redeterminations must be completed and mailed within 60 days of the receipt of the request. [Section 940(a)(1)]

Additional Information

The MRN must be written in language that is clear and understandable to the beneficiary and must be printed legibly on white paper using black ink. The MRN must include specific, required elements such as the sections outlined below:

- An *Introductory* section.
- A *Summary Statement* about the appeal decision.
- A *Summary of the Facts* section, including information specific to the appeal and background information.
- A *Decision* section stating whether the claim is covered by Medicare and whether the beneficiary is responsible for payment.
- An *Explanation of the Decision* section outlining the logic and specific reasons that led to the redetermination. This must include relevant clinical or scientific evidence used in making the redetermination.
- A *Who is Responsible for the Bill* section, with information on limitation of liability, waiver of recovery, and physician/supplier refund requirements.
- A *What to Include in Your Request for Independent Appeal* section to explain what policy was used to make the decision and identify specific documentation required to appeal at the Independent Appeal Level. It must also state that if this documentation is not introduced at the next level, it may not be introduced in subsequent appeals unless there is good cause that precluded inclusion of such evidence before.
- An *Additional Relevant Information* section to present any additional relevant information, not to include any sensitive medical information.
- A section on *Important Information About Your Appeal Rights*, including contact information and an explanation of the next level of the appeal process.

The official instruction, including a copy of a model MRN, issued to your carrier regarding this change may be found by going to:
www.cms.hhs.gov/manuals/pm_trans/R97CP.pdf

Program Inquiries

Duplicate Requests for Review

Recently, the Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Inquiries Department has been experiencing a rise in the number of duplicate requests for written reviews. This can have a significant effect on the amount of time in which our office is able to process an original request. We have found the duplicate review submission is particularly high for faxed requests.

The Centers for Medicare & Medicaid Services (CMS) allows DMERC A 45 calendar days in which to complete a review. The 45-day timeframe begins when we receive the request in our office. Currently, we are receiving numerous requests for review identical to those received in our office previously. The original requests for review are still within the 45-day processing window, however, they may not yet be completed.

CMS requires DMERC A to address all requests for review received in our office, therefore, duplicate requests serve to slow the process. Please be sure to allow sufficient time for DMERC A to complete a written review request, which could take up to 50 days (45 days for processing, plus five days for mailing), prior to submitting a duplicate request. The process is more efficient when the review processors are able to concentrate on the timely and effective completion of your original review request, rather than responding to numerous duplicate requests.

When faxing requests for review (to 570-735-9599), please be sure to fax your request only once. Our office will call and alert you if we do not receive the total number of pages listed on your coversheet.

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Telephone Reviews

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Inquiries Department has offered a telephone review service to the supplier community since June 1, 2003. In order to encourage and assist suppliers in utilizing the telephone review process, the following information is being provided, which should address some questions suppliers may have.

1. The number that should be used for the telephone reviews is 866-420-6906.

2. The hours of operation for the telephone review line are 8:00 AM-4:00 PM, Eastern Standard Time, Monday-Friday.

3. The telephone review representatives may process a maximum of three (3) reviews on each call to the telephone review line.

4. Telephone reviews are intended to replace standard reviews where there is the expectation that the review can be carried out more expeditiously and/or will ease the burden to the supplier (i.e., reviews are completed immediately). Where there would appear to be a need for a significant amount of either narrative or complex documentation, or where the appellant would benefit from a more in-depth process, then a written review request must be filed within the timely filing period (120 days from date of initial determination). Telephone reviews that involve noncomplicated adjustments can be performed, in addition to situations where a keying error occurred at DMERC A.

Examples of telephone review requests may involve the following (not all-inclusive):

- Number of services
- Modifier corrections
- Healthcare Common Procedure Coding System (HCPCS) corrections
- Unique Physician Identification Number (UPIN) corrections
- Incorrect diagnosis denials
- Inappropriate maintenance and servicing (MS) denials
- Claims incorrectly denied as duplicate charges

DMERC A is unable to conduct telephone reviews for the following:

- Return/reject [claim resubmission is required]
- Claim status [no action can be taken until a claim determination has been issued]
- Review or fair hearing status
- Review of an overpayment
- Reviews that require additional medical documentation to establish medical need [these cases should be mailed in for a written review]
- Limitation of liability [involves GA modifier and waiver statement (e.g., Advance Beneficiary Notice (ABN)]
- Good cause for timely filing

The Program Inquiries Department is unable to adjust or complete a telephone review for any claim that includes additional medical documentation where a clinical determination would be necessary.

It should also be noted, the telephone review representatives have expertise in certain medical policy groupings. They will be better able to assist suppliers if the telephone review requests are grouped together by the categories listed below.

5. Currently, there are three telephone review representatives taking telephone review requests. These individuals are experienced in processing written reviews and each has expertise in one of the three medical policy groupings (see below). Upon calling the telephone review line, the caller will be prompted to select the medical policy grouping that applies to the review request.

Medical Policy Group I:

- Continuous Positive Airway Pressure Systems (CPAP) and accessories
- Nebulizers and accessories
- Oxygen
- Ventilators
- Orthotics and Prosthetics (O&P)
- Refractive Lenses (e.g., vision claims)
- Hospital Beds
- Respiratory Assist Devices (RAD) and accessories

Medical Policy Group II:

- Wheelchairs and accessories
- Walkers and accessories
- Canes and Crutches
- Power Operated Vehicles (POVs)
- Drugs (e.g., immunosuppressive, oral anticancer, oral antiemetic)
- External Breast Prosthesis
- Transcutaneous Electrical Nerve Stimulators (TENS) and accessories
- Continuous Passive Motion Device (CPMD)

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Medical Policy Group III:

- Surgical Dressings
- End-Stage Renal Disease (ESRD equipment and supplies)
- Ostomy and Urological Supplies
- Parenteral/Enteral Nutrition (PEN pumps and supplies)
- Home Blood Glucose Monitors and supplies
- Thoracic-Lumbar-Sacral Orthoses (TLSOs)

The DMERC A Program Inquiries Department looks forward to assisting suppliers with their telephone reviews and encourages all suppliers to take advantage of this service, when applicable.

Fair Hearing/ALJ Request - Reminders

A hearing officer hearing is the second level of appeal performed after a review determination has been issued. It is a new and independent review of the claim by a hearing officer. The request **must** be in writing and signed by the party submitting the request.

There are three types of fair hearings that an appellant may request: In-person, Telephone, or On-the-Record. It is important that the type of hearing requested is specified within the request for a hearing officer hearing. If the preferred type of hearing is not specified, the case is automatically prepared as an On-the-Record hearing.

Overpayment Hearing Cases

When a hearing request is the result of an overpayment, please send as much documentation as possible to support the need for the item(s) at issue with the hearing request. This would include any documentation either sent to or received from the Region A Program Safeguard Contractor, when applicable. This documentation should include any overpayment demand letters, rebuttal letters, rebuttal responses, and information regarding specific beneficiaries, claims, or dates of service.

Timeliness Requirements

The following apply to fair hearings:

- Fair hearings must be completed in 120 days from the date of receipt in our office - DMERC A.
- A letter acknowledging receipt of the fair hearing must be sent to the appellant within 21 days from the date of receipt.
- The fair hearing cases must be forwarded to the hearing officer within 30 days from the date of receipt in our office.
- Fair hearings cases must be effectuated within 30 days from the date of the hearing decision.

The following apply to Administrative Law Judge (ALJ) hearings:

- A letter acknowledging the receipt of an ALJ request must be sent to the appellant within 30 days from the date of receipt in our office - DMERC A.
- The ALJ cases must be forwarded to the Office of Hearings and Appeals within 21 days from the date of receipt in our office.
- The ALJ cases must be effectuated within 30 days from the date we receive the case back in our office.
  NOTE: There can be a significant delay in the time the appellant receives a copy of the decision from the ALJ and the time Program Inquiries receives the case back in our office from the ALJ. It is necessary for our office to have the entire case, rather than a copy of the decision, in order to effectuate the ALJ decision.

Helpful Hints for Filing a Hearing Request

When submitting a request for a fair hearing, you **must** include the following information with each hearing request.

1. The name and provider number of the supplier requesting the hearing, along with a contact name and telephone number.
2. Document the type of hearing you are requesting (i.e., In-person, Telephone, or On-the-Record).
3. For each beneficiary involved in the hearing request(s) include:
   - Beneficiary Name;
   - Health Insurance Claim Number;
   - Internal Control Number;
   - Date of Service; and
   - Procedure Code.
4. Include a copy of the review determination letter(s) you received.
5. If the hearing request is the result of an

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overpayment, include a copy of the overpayment letter.

6. Always include any and all additional documentation you would like added to the case file for consideration during the hearing.
7. Ensure any handwritten request for a hearing is legible.
8. When faxing a request for a hearing, ensure that all pages are transmitted successfully. Be sure to use the appropriate fax number: 570-735-9599.
9. The request for a hearing MUST be in writing and signed by the submitting party or their authorized representative.
10. The request must state the dissatisfaction with the carrier's review determination, or reason for an overpayment, and a desire to appeal the matter further.

A Fair Hearing Request Form has been developed to assist suppliers when submitting requests for fair hearings. While the use of this form is not mandatory, it will help to ensure that all necessary information is included with the request. (*Note*: Include additional sheets as necessary, however, make sure they contain the same information as indicated on the form.) **This form is available via the "Education - Articles and Publication Highlights" section of the Region A Durable Medical Equipment Regional Carrier Web site at: *www.umd.nycpic.com/dmeduc.html***

Program Education & Training

Reminder: Added Documentation

The Region A Durable Medical Equipment Regional Carrier (DMERC A) has recently seen an increase in calls regarding the added documentation procedure. This article serves as a reminder that there are several resources in reference to this procedure.

The following *DMERC Medicare News* articles were recently published with details on the submission of hardcopy additional documentation:

- "Additional Documentation Reminder," page 4 of the December 2003 edition (Number 68)
- "Important: Added Documentation Reminder," page 15 of the March 2004 edition (Number 69)

If it is necessary to send hardcopy additional documentation, a coversheet must be used. The coversheet can be obtained via the DMERC A Web site at: ***www.umd.nycpic.com/extra.html***

DMERC A also developed a "suggested list" of abbreviations to assist in the submission of additional documentation via electronic format. This list, which is available via our Web site at: ***www.umd.nycpic.com/edidocfiles.html***, can be used to facilitate enhanced use of the narrative fields within the Health Insurance Portability and Accountability Act (HIPAA) compliant electronic format.

Frequently Asked Questions (FAQs) Reminder

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department currently publishes two types of FAQs - seminar and quarterly.

Seminar FAQs are questions received during the PET seminars and are published after each round. These FAQs can be obtained via the DMERC A Web site at: ***www.umc.nycpic.com/dmeduc_seminars.html***

Quarterly FAQs are published as a result of the top ten inquiries, received by the Caller Information Network from the supplier community, on a quarterly basis. These FAQs can be obtained via our Web site at: ***www.umd.nycpic.com/dmercfaq.html***

DMERC A encourages the supplier community to access these FAQs on a regular basis and to familiarize themselves with the variety of questions that are being presented. This may aid in the resolution of unnecessary telephone calls to DMERC A. Also, this information can acquaint the supplier community of the answers to the same questions they may have regarding durable medical equipment.

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If you would like to be notified of the availability of FAQs, please sign up for the DMERC A ListServe at: ***www.umd.nycpic.com/dmlistserve.html#DMERCA***
(*Note*: See the article on page 31 for more information.)

Claim Submission Errors for the Second Quarter of Fiscal Year 2004

Claim submission errors (CSEs) are errors made on a claim that would cause the claim to reject upon submission to the Region A Durable Medical Equipment Regional Carrier (DMERC A). The top ten American National Standards Institute (ANSI) CSEs, for January 1, 2004, through March 31, 2004, are provided in the following chart. The total number of ANSI errors for this period was **262,471**.

ANSI Error Number - Narrative (Total errors)	Reason for Error
1) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question (47,041 errors)	The question number entered is not valid for the DMERC CMN you are sending.
2) 40022 - Procedure Code/ Modifier Invalid (31,610 errors)	The procedure code and/or modifier used on this line is invalid.
3) 11285 - Invalid Telephone Number Format (16,233 errors)	The telephone or fax number is invalid. This should be exactly ten (10) numeric digits and contain no symbols.
4) 40073 - Dates of Service Invalid with Procedure (9,740 errors)	The procedure code used is not valid for the dates of service used.
5) 40021 - Capped Rental "K" Modifier Missing (8,563 errors)	The procedure code submitted is a capped rental item, which requires a modifier of KH, KI, or KJ.
6) 40067 - Invalid/Unnecessary CMN Version Submitted (7,760 errors)	The DMERC CMN version number entered is not valid for the Healthcare Common Procedure Coding System (HCPCS) code submitted.
7) 20025 - ID Code Qualifier Invalid (7,728 errors)	The qualifier identifying the referring provider identification number for this claim is invalid.
8) 40066 - Invalid/Unnecessary CMN Submitted (7,511 errors)	The DMERC CMN form number entered is not valid for the HCPCS code submitted.
9) 11272 - Nine Numeric Digits Required (6,734 errors)	The billing provider Employer Identification Number (EIN) or Social Security Number (SSN) should be exactly nine (9) numeric digits and contain no symbols.
10) 40014 - Ordering Provider Information Missing (6,730 errors)	The ordering provider information is missing. This should be included with every service line.

In an effort to reduce other initial claim denials, the below information represents the top ten return/reject denials for the second quarter of Fiscal Year 2004. Claims denied in this manner are considered to be unprocessable and **have no appeal rights**.

An unprocessable claim is any claim with incomplete or missing required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally. (Refer to Chapter 1, Section 80.3.1 of Pub. 100-4, Medicare Claims Processing Manual.)

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
1) M81 - Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity. (23,000 claims)	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties **must** use an ICD-9-CM code number coded to the highest level of specificity. You may enter up to four codes in priority order (i.e., primary, secondary condition).
2) CO 16 M51 - Claim/ service lacks information which is neededfor adjudica-	**Item 24D** - Enter the procedures, services, or supplies using the Healthcare Com-

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Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
tion. Missing/incomplete/ invalid procedure codes(s) and/or rates. (13,394 claims)	mon Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.
3) CO 16 M78 - Claim/ service lacks information which is needed for adjudication. Missing/incomplete/ invalid HCPCS modifier. (7,506 claims)	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable, show HCPCS modifiers with the HCPCS code.
4) CO 16 MA 83 - Claim/ service lacks information which is needed for adjudication. Did not indicate whether we are the primary or secondary payer. (6,117 claims)	**Item 11** - Enter the name of the enrollee in a Medigap policy, if different from Item 2. Otherwise, write "SAME." If no Medigap benefits are assigned, leave blank. Item 11 **must** be completed. If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE."
5) CO 16 MA 102 - Claim/ servicelacks information which is needed for adjudica. -tion. Missing/incomplete/ invalid name or provider identifier for the rendering/ referring/ordering/supervising provider. (5,818 claims)	**Item 17** - Enter the name of the referring or ordering physician. *AND/OR* **Item 17A** - Enter the Unique Physician Identification Number (UPIN).
6) CO 16 N64 - Claim/ service lacks information which is needed for adjudication. The"from" and "to" dates must be different. (5,643 claims)	**Item 24A** - Enter the precise eight-digit date (MMDDCC YY) for each procedure, service, or supply.
7) CO 16 MA82 - Claim/ service lacks information which is neededfor adjudication Missing/incomplete/ invalid provider/supplier billing number/identifier or identifier or billing name, address, city, state, zip code, orphone number. (4,361 claims)	**Item 33** - Enter the provider of service/supplier's billing name, address, zip code, and telephone number. Enter the PhysicianIdentification Number (PIN) for the performing provider of service/supplier who is not a member of a group practice. Enter the group PIN for the performing provider of service/supplier who is a member of a group practice.
8) CO 16 M77 - Claim/ service lacks information which is needed for adjudication. Missing/incomplete/ invalid place of service. (3,063 claims	**Item 24B** - Enter the appropriate place of service code(s). Identify the location, using a place of service place of service code for each item used or service performed.
9) CO 16 M53 - Claim/ service lacks information which is needed for adjudication. Missing/incomplete/ invalid days or units of service. (652 claims)	**Item 24G** - Enter the number of days or units.
10) CO 16 M79 - Claim/ service lacks information which is needed for adjudication. Missing/incomplete/ invalid charge. (432 claims)	**Item 24F** - Enter the charge for each listed service.

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 <u>each</u> claim. DMERC A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency.

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. Members of this group play a vital role in assisting PET with our educational efforts and in ensuring these efforts are both meaningful and helpful to the provider community as a whole.

The second quarterly meeting for Fiscal Year 2004 was held via teleconference on February 11, 2004. Participants included representatives from the Centers for Medicare & Medicaid Services (CMS); , the Region A Program Safeguard Contractor (PSC), TriCenturion; billing services; state provider associations; and individual provider organizations. Topics addressed at

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this meeting included:

- DMERC A Web site
- Caller Information Network Update
- Supplier Manual Update
- DMERC A Bulletins
- Seminar Frequently Asked Questions (FAQs)
- Updates from CMS
- PCOM Advisory Group Membership Criteria
- WebEx Online Seminars
- Data Analysis
- Current Educational Outreach
- Future Educational Opportunities and Plans
- *Medlearn Matters…Information for Medicare Providers* (Change Request (CR) 3129)
- Change in Data Reports (CR 2305)
- Additional Documentation

Minutes from all quarterly meetings are available via the "PCOM Advisory Group" section of the DMERC A Web site at: ***www.umd.nycpic.com/dmerc_PCOM.html***. In addition to the meeting minutes, this site also contains general information about the PCOM Advisory Group, membership listings, and instructions on becoming a member.

DMERCs Attend the National Home Infusion Association (NHIA) Annual Conference and Medtrade in Las Vegas

Staff from the Region A Durable Medical Equipment Carrier (DMERC A) Program Education & Training (PET) Department attended the NHIA annual conference, held March 1-4, 2004, and the **Medtrade** show, held March 16-18, 2004. Both events were held in Las Vegas, NV, and all four DMERCs shared exhibit space. This joint effort gave providers an opportunity to interact with all of the DMERCs in one location.

NHIA is a trade association that represents and advances the interests of organizations and individuals that provide infusion and specialized pharmacy products and services to the entire spectrum of home-based patients. Attending this event was a variety of healthcare professionals, including pharmacists, physicians, nurses, and providers. DMERC A participated in several roundtable discussions, as well as one-on-one interaction with attendees. For more information, please visit the NHIA Web site at: ***www.nhianet.org***

At **Medtrade**, DMERC A staff provided access to our Web site, along with assistance in the navigation of the site, the Region A Program Safeguard Contractor Web site, and various Centers for Medicare & Medicaid Services (CMS) Web sites. DMERC A also participated in the "DMERC Issues Update" educational session, along with representatives from the other DMERCs. Each representative gave an update on their respective activities and initiatives and provided updates on some of the "hot topics" within the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) industry.

In addition to the "DMERC Issues Updates," members from the DMERC A Electronic Data Interchange (EDI) Department participated in an "EDI Update" session.

PET recognizes these events as an ideal opportunity to personally interact with and offer continued availability to the DMEPOS community, and we look forward to seeing you at next year's events.

Web Site

New Electronic Data Interchange (EDI) ListServe

An EDI-specific ListServe is now available on the Region A Durable Medical Equipment Regional Carrier Web site. The EDI ListServe will be used to notify subscribers of important announcements and messages pertaining to EDI. If you submit claims electronically, it is strongly recommended that you sign up for the EDI ListServe.

To join, visit the "EDI ListServe" section of our Web site (***www.umd.nycpic.com/edilistserve.html***), then follow the instructions to subscribe.

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Region A Provider Information

Both the Region A Durable Medical Equipment Regional Carrier (DMERC A) and Program Safeguard Contractor (PSC) 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, ListServes, what's new, etc. Online versions of the *DMERC Medicare News* are also available via this Web site.

Providers can gain access to the PSC Web site via the "TriCenturion" 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 Coverage Determinations (LCDs). Recent updates involving medical policy development, medical review, or benefit integrity can be acessed by visiting the PSC "What's New" section at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

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

- ***www.cms.hhs.gov***
  (CMS Home page)
- ***www.cms.hhs.gov/coverage***
  (Medicare Coverage Home page)
- ***www.cms.hhs.gov/medicare***
  (Medicare Information Resource)
- ***www.cms.hhs.gov/manuals***
  (Medicare and Medicaid Program Instructions)

(*Note*: Refer to the following articles for more Web sites.)

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services 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 Quarterly Provider Update can be accessed at: ***www.cms.hhs.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]

Provider/Supplier Audience Web Page Updates

The Centers for Medicare & Medicaid Services (CMS) wants to ensure providers and health care practitioners have quick access to accurate Medicare program information. In keeping with this goal, the provider and supplier-specific Web pages listed below are a one-stop resource, focused on the informational needs and interests of Medicare providers, including physicians and other practitioners.

NEW Provider/Supplier Web Pages include:

- **Emergency Medical Treatment & Labor Act (EMTALA)** - Content includes Policy, Regulations, Manuals, Frequently Asked Questions and more.
  www.cms.hhs.gov/providers/emtala
- **End-Stage Renal Disease (ESRD) Information Resource** - Content includes Regulations, Coverage, Billing, Demonstrations, CROWN, Forms, Network Organizations, Public Use Files, Publications, Dialysis Facility Compare, and more.
  www.cms.hhs.gov/providers/esrd.asp
- **Practice Administration Information Resource for Medicare** - Content includes up-to-date information and tools as they relate to Administrators, Coders, Billing Personnel, and others outside the traditional provider role.
  www.cms.hhs.gov/providers/pair
- **Ambulatory Surgical Centers (ASC)** - Content includes information on Enrollment/Participation, Payment Rates, Regulations, and more.
  www.cms.hhs.gov/suppliers/asc
- **Federally Qualified Health Centers (FQHC)** - Content includes Regulations, Health Insurance Portability and Accountability Act (HIPAA), Enrollment, Frequently Asked Questions, Forms, Manuals, Publications, and more.
  www.cms.hhs.gov/providers/fqhc

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- **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)** - Content includes Billing Instructions, Coding, Payment, Medical Review information, and more.
  www.cms.hhs.gov/suppliers/dmepos
- **Home Health Agencies (HHA)** - Content includes Regulations, Coding, Billing, Outcome and Assessment Information Set (OASIS) and Outcome-Based Quality Improvement (OBQI), and more.
  www.cms.hhs.gov/providers/hha
- **Hospice** - Content includes Certification, Educational Articles, Frequently Asked Questions, Research and Statistics information, and more.
  www.cms.hhs.gov/providers/hospiceps
- **Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS)** - Content includes useful information related to the development of a PPS for Medicare inpatient psychiatric services, including Background and Coding information, the proposed Regulation and Assessment Tool, and more.
  www.cms.hhs.gov/providers/ipfpps
- **Mammography Services** - Content includes Coding, Policies/Regulations, helpful Resources, and more.
  www.cms.hhs.gov/suppliers/mammography
- **Rural Health Clinics** - Content includes Regulations, Enrollment, Coverage, Publications, Forms, Manuals, and more.
  www.cms.hhs.gov/providers/rh
- **Skilled Nursing Facilities (SNF) PPS** - Content includes Regulations, Publications, Rates and Indices, Minimum Data Set (MDS), Swing Bed, Frequently Asked Questions, and more.
  www.cms.hhs.gov/providers/snfpps

NEW Provider Web Tools include:

- **Medicare Physician Fee Schedule Lookup** - View physician service information, geographic practice cost indices, and payment policy.
  www.cms.hhs.gov/physicians/mpfsapp
- **National Correct Coding Initiative (NCCI) Edits** - The NCCI promotes uniformity among the contractors that process Medicare claims in interpreting Medicare payment policies. The edits are pairs of services that normally should not be billed by the same provider for the same patient on the same day.
  NCCI Edits for Physicians -
  www.cms.hhs.gov/physicians/cciedits
  NCCI Edits for Hospital Outpatient Departments -
  www.cms.hhs.gov/providers/hopps/cciedits
- **Medlearn Matters…Information for Medicare Providers** - This page includes links to educational articles and related Change Requests, in order to present consistent information to providers.
  www.cms.hhs.gov/medlearn/matters

Provider and supplier-specific Web pages can be accessed from ***www.cms.hhs.gov/providers*** or ***www.cms.hhs.gov/suppliers***. From the CMS Home page, click on "Providers" from the left navigation bar under "Topics," or search under the "Professionals" tab or drop-down menu.

Specialized information on these one-stop resource pages includes links to Federal Regulations and Notices, Transmittals/Change Requests, and Frequently Asked Questions. General information includes links for Coverage, Coding, Program Integrity/Medical Review, and a wealth of other subjects that would be of interest to all audiences. Each page also has a "Highlights" section to emphasize important and timely information, such as pertinent regulations, instructions, or conferences. Providers, physicians, and suppliers can now go to ***www.cms.hhs.gov/mailinglists*** to subscribe to ListServes for various Medicare audiences or categories.

DMERC A ListServes

DMERC A ListServes - general and Supplier Manual - are no-charge features on our Web site. To receive email notification of the availability of Medicare program and supplier manual updates posted to our Web site, subscribe to the ListServes by visiting: ***www.umd.nycpic.com/dmlistserve.html***, then follow the instructions to subscribe. Subscribe to the Region A Program Safeguard Contractor ListServe by visiting: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

The Pulse of CMS

The Centers for Medicare & Medicaid Services (CMS) provided the Region A Durable Medical Equipment Regional Carrier (DMERC A) with copies of a Special Edition and the Spring 2004 edition of "The Pulse of CMS." These regional publications, for health care professionals, are available via the "Education - Articles and Publication Highlights" section of the DMERC A Web site at: ***www.umd.nycpic.com/dmeduc.html***. (*Note*: These are Portable Document Format (PDF) files, therefore, please click on the PDF icon for the download instructions.)

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Telephone Numbers

Caller Information Network	
Supplier Toll-Free Line	866-419-9458
Beneficiary Toll-Free Line (DMERC A)	800-842-2052
Beneficiary Toll-Free Line (National)	800-MEDICARE (800-633-4227)
EDI Services Help Desk	866-861-7348
Program Education & Training	570-735-9666
Program Inquiries	
Telephone Reviews Line	866-420-6906
FAX Numbers	
Check Control/MSP	570-735-9594
Electronic Data Interchange	570-735-9510
Extra Documentation	570-735-9402
Program Education & Training	570-735-9442
Program Inquiries (Hearings & Reconsideration)	570-735-9599
National Supplier Clearinghouse	866-238-9652
SADMERC	877-735-1326

Web Sites

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

Addresses

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

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

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

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

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

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

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

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

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

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

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

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MEDICARE

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

A CMS Contracted Carrier