# DMERC Medicare News

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





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



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

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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# Billing

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

The annual home health (HH) consolidated billing update for calendar year 2004 was published in the December 2003 *DMERC Medicare News*. Among other changes, this update added Healthcare Common Procedure Coding System (HCPCS) codes A7525 and A7526 to the list of supply codes subject to home health consolidated billing. These codes were added in error.

This is to notify providers that the following codes will not be added to home health consolidated billing enforcement:

| | |
|---|---|
| A7525 | Tracheostomy mask, each |
| A7526 | Tracheostomy tube collar/holder, each |

This correction is reflected in the HH consolidated billing master code list, which is available via the Centers for Medicare & Medicaid Services (CMS) Web site at ***www.cms.hhs.gov/providers/hhapps/#billing***.

[Reference: Change Request (CR) 3024; Transmittal 62]

## Billing Implications - DMEPOS Fee Schedule Update for 2004

In accordance with Section 302(c) of the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA) of 2003, the fee schedule update factors for 2004 for durable medical equipment (DME), other than items classified as class III devices by the Food and Drug Administration (FDA), prosthetic devices, prosthetics, orthotics and surgical dressings are equal to 0 percent. In addition, the 2004 payment limits for therapeutic shoes will be frozen at the 2003 amounts. The following are the Healthcare Common Procedure Coding System (HCPCS) codes listed by fee schedule payment category for DME classified as class III devices by the FDA:

Inexpensive or Routinely Purchased (IN)

E0691 E0692 E0693 E0694 E0747 E0748
E0760 E0782 E0783 E0785 E0786 K0600
K0607 K0609

Capped Rental (CR)

E0617 E0749 K0606

DME Supply (SU)

K0608

The fee schedule amounts for the items listed above and any items classified by the FDA as class III devices that are billed under HCPCS code E1399 (durable medical equipment, miscellaneous) are not subject to the freeze and will receive a covered item update of 2.1 percent for 2004. Effective for claims received on or after April 1, 2004, with dates of service on or after January 1, 2004, modifier **KF** should be submitted along with the applicable HCPCS code for all DME items classified by the FDA as class III devices.

Elevating, stair climbing power wheelchairs were recently cleared by the FDA for marketing and are class III devices. The base power wheelchair portion of this device would normally fall under HCPCS code K0011 (programmable power wheelchair base). However, because this device is not subject to the payment freeze, for claims received before April 1, 2004, with dates of service on or after January 1, 2004, the base wheelchair for this device should be billed using HCPCS code E1399 and paid using the 2003 fee schedule amounts for code K0011 increased by 2.1 percent. For claims received on or after April 1, 2004, with dates of service on or after January 1, 2004, modifier **KF** should be submitted along with HCPCS code K0011 for the base power wheelchair for this device. For claims received on or after January 1, 2004, with dates of service on or after January 1, 2004, the elevation feature for this device should be billed using HCPCS code E2300 and the stair climbing feature for this device should be billed using HCPCS code A9270.

[Reference: Change Request (CR) 3020; Transmittal 35]

## New Bases for Medicare Drug Payment Amounts for DMERCs

Payments for drugs billed to Durable Medical Equipment Regional Carriers (DMERCs) will be based on the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act (DIMA)

of 2003, beginning January 1, 2004, and will be paid at 85 percent of the Average Wholesale Price (AWP) for Healthcare Common Procedure Coding System (HCPCS) payment amounts based on the April 1, 2003, fee schedule. Exceptions to this calculation are as follows:

- The payment limits for infusion drugs furnished through an item of durable medical equipment on or after January 1, 2004, will be 95 percent of the October 1, 2003, AWP.
- The payment limits for new drugs or biologicals is 95 percent of the AWP. A new drug is defined as an unlisted drug (not currently covered by a HCPCS code) that was approved by the Food and Drug Administration (FDA) subsequent to April 1, 2003. A drug would not be considered new if: the brand or manufacturer of the drug changed; a new formulation of the vial size is developed; or the drug received a new indication.
- The payment limits for certain drugs studied by the Office of Inspector General (OIG) and General Accounting Office (GAO) are based on the percentages of the April 1, 2003, AWPs specified in Table 1 in §20 of Chapter 17 of the Medicare Claims Processing Manual, Pub. 100-4.

Payment limits determined under this calculation shall not be updated during 2004.

[Reference: Change Request (CR) 3025; Transmittal 55]

# Renewed Moratorium on Outpatient Rehabilitation Therapy Caps

The following information affects providers of outpatient physical therapy, speech-language pathology, and occupational therapy services.

## Background

The Balanced Budget Act (BBA) of 1997 required payment under a prospective payment system for outpatient rehabilitation services (physical therapy, speech-language pathology, and occupational therapy), and also set financial limitations for these services.

The Balanced Budget Refinement Act (BBRA) of 1999 placed a two-year moratorium on these limitations effective January 1, 2000, through December 31, 2001. This moratorium was further extended through December 31, 2002, by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

In 2003, although there was not a moratorium on these payment limitations, their implementation was delayed until September 1, 2003. The financial limitations remain in effect for services provided and claims received for those services from September 1, 2003, through December 7, 2003, when the Medicare Prescription Drug Modernization Act of 2003 renewed the moratorium until the end of calendar year 2005.

## Impact to You

Beginning December 8, 2003, and continuing through December 31, 2005, there are no payment caps on claims received for the physical therapy, speech-language pathology, and occupational therapy services. The payment caps for these services remain in effect for claims received on September 1, 2003, through December 7, 2003, for services rendered during that timeframe.

## What You Need to Know

The recently-enacted Medicare Prescription Drug Modernization Act of 2003 renewed the moratorium on physical therapy, speech-language pathology, and occupational therapy services payment caps, effective on December 8, 2003, and continuing through calendar year 2005. The payment cap on services provided and for which claims were received from September 1, 2003, through December 7, 2003, for outpatient physical therapy and speech-language pathology services combined remains $1590 and for outpatient occupational therapy services remains $1590. These caps are based on the allowed incurred expenses, which are defined as the Medicare Physician Fee Schedule (MPFS) amount before the application of any beneficiary deductible and/or coinsurance. Caps apply to claims received during the time caps were in effect.

## What You Need to Do

You need to know that the payment caps for these services will not be in effect on claims received from December 8, 2003, through December 31, 2005; therefore, you should not limit services or charge

beneficiaries for these covered services based on therapy caps. Essentially, the Medicare payment policies with regard to the cap are the same as those prior to September 1, 2003. **Note that the use of therapy modifiers is still required.**

### Related Instructions

To learn more about these issues, look for CR 3005 on the Medicare Web site page for 2003 transmittals. For example, that transmittal contains some specific examples of how the caps are computed for the period from September 1, 2003, through December 7, 2003. The transmittal page may be accessed at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

Should you have any questions, please contact your local Medicare carrier or fiscal intermediary. To find your local Medicare contractor, please visit: ***www.cms.hhs.gov/medlearn/tollnums.asp***

### Important Dates to Know

This Change Request was implemented on December 8, 2003, and was effective on December 8, 2003.

[Reference: Change Request (CR) 3045; Transmittal 40]

The Region A Durable Medical Equipment Regional Carrier (DMERC A) posted an exerpt, from the related instructions referenced above, to the "Billing" section of our Web site on December 19, 2003. In addition, this information can be found in Pub. 100-4, Medicare Claims Processing Manual, Chapter 5, by visiting the Centers for Medicare & Medicaid Services (CMS) Online Manual System at ***www.cms.hhs.gov/manuals/***.

[Reference: Change Request (CR) 3005; Transmittal 42]

# Jurisdictional Payment for Services

### Payment Jurisdiction for Services Paid Under the Physician Fee Schedule and Anesthesia Services

The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the zip code. Though a number of additional services appear on the MPFS database, these payment jurisdiction rules apply only to those services actually paid under the MPFS and to anesthesia services. (For example, it does not apply to clinical lab, ambulance, or drug claims.)

Effective for claims received on or after April 1, 2004, carriers must use the zip code of the location where the service was rendered to determine carrier jurisdiction over the claim and the correct payment locality. The following instructions for paper and electronic claim submission should be followed for claims received on or after April 1, 2004:

- For paper claims, the instructions for completing Item 32 to indicate the service location have been revised to read as follows:

  **Item 32** Effective for claims received on or after April 1, 2004: the name, address, and zip code of the service location for all services other than those furnished in place of service home - 12 must be entered; and on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms must be submitted.

- For electronic claims, the following instructions apply. Please note that these instructions do not apply to services rendered at place of service (POS) home -12. For services rendered at POS home -12, the address on the beneficiary file is used to determine the pricing locality.

  Per the implementation guide of the 4010/4010A1 version of the ASC X12N 837, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address must be entered for each service at the line level, if that location is different from the billing provider, pay-to provider, or claim level service facility location.

  When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address must be entered at the claim level loop 2310D.

  If the POS code is the same for all services, but the services were provided at different addresses, each service must be submitted with line level information. This will provide a zip code to price each service on the claim.

### Payment Jurisdiction for Purchased Services

Diagnostic tests and their interpretations are paid on the MPFS. Therefore, they are subject to the same jurisdictional payment rules as all other services paid on the MPFS. Additional explanation is provided here due to general confusion concerning these services when they are purchased and then billed, rather than rendered and billed by the billing entity. As for any other services, suppliers must also meet current enrollment criteria as stated in Chapter 10 of the Program Integrity Manual in order to be able to enroll and bill for purchased tests and interpretations. That these services are purchased does not negate the need for appropriate enrollment procedures with the carrier that has jurisdiction over the geographic area where the services were rendered.

Suppliers may receive payment for purchased interpretations. The purchased interpretation must be billed to the carrier that has jurisdiction over the geographic location where the interpretation was performed. Therefore, suppliers must enroll with the carrier that has jurisdiction over the geographic location where the purchased interpretation was performed (i.e., the supplier must submit the interpretation service component to the carrier that would be billed by the interpreting physician if the interpretation hadn't been purchased).

Physicians may receive payment for purchased diagnostic tests. However, they must bill that test to the carrier that has jurisdiction over the geographic location where the test was performed. Therefore, physicians must enroll with the carrier that has jurisdiction over the geographic location where the test was performed (i.e., the carrier that would be billed by the test supplier if the test component hadn't been purchased).

Effective for claims received on or after April 1, 2004, in order to allow the carrier to determine jurisdiction, price correctly, and apply the purchase price limitations, global billing will not be accepted for purchased services on electronic or paper claims. Claims received with global billings in this situation will be treated as unprocessable. The technical and professional components of the service must be submitted on separate lines of the claim. Electronic claims submitted for purchased services may be submitted with the interpretation and the test on the same claim. In order for the carrier to pay the correct locality based fee, appropriate service facility service location information must be submitted at the line level when services are rendered at different locations. If line item data is not submitted, it will be assumed by the carrier that the services were rendered at the same service facility location.

Effective for claims received on or after April 1, 2004, when billing for purchased tests on the Form CMS-1500 paper claim form, each test must be submitted on a separate claim form. In this way, the appropriate service facility location zip code and the purchase price of each test will be submitted and the carrier will be able to pay the correct reimbursement rates. Item 32 on the Form CMS-1500 paper claim is limited to one service facility location name and address. In most cases, when a test is purchased, it has been rendered at a different service facility location from where the interpretation is performed. Therefore, a physician may only bill for a purchased test and an interpretation on the same claim when the services are rendered on the same date of service and at the same service facility location, and are submitted with the same place of service codes.

Effective for claims received on or after April 1, 2004, multiple purchased tests may be submitted on electronic claims as long as appropriate service facility location information is submitted when services are rendered at different locations and the appropriate total purchased service amounts are submitted for each purchased test.

[Reference: Change Request (CR) 2912; Transmittal 6]

## Treatment of Certain Dental Claims as a Result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The following information affects dentists. Providers who submit dental claims for services provided to Medicare beneficiaries need to be aware of the new law

related to claims submissions to supplemental or other group health insurers of Medicare beneficiaries.

### Background

Under present law, the Medicare benefit does not include coverage of most dental services. Some insurers have required dentists to receive a claim denial from Medicare before they will process a claim from the dentist for a Medicare beneficiary holding coverage from that group health insurer. Under Section 950 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, a group health plan providing supplemental or secondary coverage to Medicare beneficiaries cannot require dentists to obtain a claim denial from Medicare for dental services that are not covered by Medicare before paying the claim. However, a claims determination, i.e., a submission of a claim to Medicare, **may be required** for inpatient dental hospital services or dental services **specifically covered** by Medicare. (Payment may be made under part A for these services.)

This section of the new legislation is to be effective 60 days after enactment of the legislation, which was enacted on December 8, 2003. Thus, this provision is effective as of February 8, 2004.

### Impact to You

As of February 8, 2004, for **outpatient** dental services that are not covered by Medicare, you do not need to submit a claim to Medicare and receive a denial if the beneficiary has group secondary or supplemental coverage. Group health plans are prohibited from requiring such determinations as of February 8, 2004, for such services.

### What You Need to Know

A group health plan may continue to require such determinations in cases involving or appearing to involve inpatient dental hospital services, or other dental services covered by Medicare.

### What You Need to Do

Please amend your procedures regarding dental service claims for Medicare patients as reflected by the new legislation. See the Additional Information section for further illumination.

### Additional Information

For your convenience, the actual text of Section 950 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 reads as follows:

**"Sec. 950. Treatment of Certain Dental Claims**

(a) In General—Section 1862 (42 U.S.C. 1395y) is amended by adding at the end, after the subsection transferred and redesignated by section 948 (a), the following new subsection:

(k) (1) Subject to paragraph (2), a group health plan (as defined in subsection (a) (1) (A) (v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a Medicare claims determination under this title for dental benefits specifically excluded under subsection (a) (12) as a condition of making a claims determination for such benefits under the group health plan.

(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act."

## Temporary HCPCS Codes for Billing Spinal Orthotics

Level II Healthcare Common Procedure Coding System (HCPCS) codes may be issued quarterly to provide for new or changed Medicare coverage policy for services normally described in Level II. These codes may be temporary and be replaced by a Level I or Level II code in the related HCPCS code section, or may remain for a considerable time as "temporary" codes. (Refer to Chapter 23, Section 20, of Pub. 100-4, Medicare Claims Processing Manual, for a description of HCPCS, which is available via the Centers for Medicare & Medicaid Services (CMS) Online Manual System at ***www.cms.hhs.gov/manuals/***.)

Effective April 1, 2004, new "K" codes (K0630-K0649) will be established for billing spinal orthotics and added to the system. Codes L0476, L0478, L0500, L0510, L0520, L0530, L0540, L0550, L0560, L0561, L0565, L0600, L0610, L0620, and L0960 will be invalid for claims submission on or after April 1, 2004. For more

information, please refer to the article "Spinal Orthoses - New Codes" under the January 2004 Bulletins listed on the "What's New" page of the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

[Reference: Change Request (CR) 2967; Transmittal 50]

## Change in Coding for Darbepoetin Alfa and Epoetin Alfa

Effective for services furnished on or after January 1, 2004, new Healthcare Common Procedure Coding System (HCPCS) codes were established for End Stage Renal Disease (ESRD) dialysis billing. For more information, please refer to the article "Epoetin and Darbepoetin - New Codes" under the January 2004 Bulletins listed on the "What's New" page of the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

[Reference: Change Request (CR) 2963; Transmittal 39]

## Intravenous Immune Globulin

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, as of January 1, 2004, covers intravenous immune globulin in the home for treatment of primary immune deficiency diseases. Under this policy, the drug is paid for when administered in the home, however, supplies and items related to the drug's administration (e.g., infusion pump) are not. For more information, please refer to the article "Intravenous Immune Globulin - New Benefit" under the March 2004 Bulletins listed on the "What's New" page of the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm***. Providers should also refer to the Centers for Medicare & Medicaid Services (CMS) article at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3060.pdf***. (Note: Please see the *Medlearn Matters* article on page 26, for more on CMS articles for providers.)

[References: Change Request (CR) 3059, Transmittal 6; CR 3060, Transmittal 74]

# EDI & HIPAA

## Remittance Advice Remark Code and Claim Adjustment Reason Code Update

### X12N 835 Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers, including Medicare, have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment.

The complete list of remark codes is available at ***www.cms.gov/providers/edi/hipaadoc.asp*** and ***www.wpc-edi.com/codes/Codes.asp***. The list is updated three times a year, in the months following X12 trimester meetings. The following list summarizes changes made from March 1, 2003, to June 30, 2003.

| Code | Current Narrative |
|---|---|
| N202 | Additional information/explanation will be sent separately. |
| N203 | Missing/incomplete/invalid anesthesia time/units. |
| N204 | Services under review for possible pre-existing condition. Send medical records for prior 12 months. |
| N205 | Information provided was illegible. |
| N206 | The supporting documentation does not match the claim. |
| N207 | Missing/incomplete/invalid birth weight. |
| N208 | Missing/incomplete/invalid DRG code. |
| N209 | Missing/invalid/incomplete taxpayer identification number (TIN). |
| N210 | You may appeal this decision. |
| N211 | You may not appeal this decision. |

**Modified Remark Codes:**

| Code | (Modification Date) - Current Modified Narrative |
|---|---|
| M13 | (Modified 6/30/03) - Only one initial visit is covered per specialty per medical group. |
| M18 | (Modified 6/30/03) - Certain services may be approved for home use. Neither a hospital nor a skilled nursing facility (SNF)is considered to be a patient's home. |
| M25 | (Modified 6/30/03) - Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment. |
| M26 | (N/A) - Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice.<br>The law permits exceptions to the refund requirement in two cases:<br>• If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or<br>• If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service<br>If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position.<br>If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.<br>The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.<br>The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.<br>The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.<br>Contact this office if you have any questions about this notice. |
| M60 | (Modified 6/30/03) - Missing/incomplete/invalid Certificate of Medical Necessity. |
| M86 | (Modified 6/30/03) - Service denied because payment already made for some/similar procedure within set time frame. |
| M117 | (Modified 6/30/03) - Not covered unless submitted via electronic claim. |
| M129 | (Modified 6/30/03) - Missing/incomplete/invalid indicator of x-ray availability for review. |
| M134 | (Modified 6/30/03) - Performed by a facility/supplier in which the provider has a financial interest. |
| MA01 | (Modified 6/30/03) - If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late.<br>An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.<br>If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met. |
| MA02 | (Modified 6/30/03) - If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 120 days of the date of this notice. Decisions made by a Quality |

| Code | (Modification Date) - Current Modified Narrative |
|---|---|
| | Improvement Organization (QIO) must be appealed to that QIO within 60 days.<br><br>An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal. |
| MA03 | (Modified 6/30/03) - If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.<br><br>An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal. |
| MA20 | (Modified 6/30/03) - Skilled nursing facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence. |
| MA24 | (Modified 6/30/03) - Christian science sanitarium/skilled nursing facility (SNF) bill in the same benefit period. |
| MA93 | (Modified 6/30/03) - Non-PIP (Periodic Interim Payment) Claim. |
| MA101 | (Modified 6/30/03) - A skilled nursing facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents. |
| MA106 | (Modified 6/30/03) - PIP (Periodic Interim Payment) claim. |
| MA121 | (Modified 6/30/03) - Missing/incomplete/invalid date the x-ray was performed. |
| N30 | (Modified 6/30/03) - Patient ineligible for this service. |
| N32 | (Modified 6/30/03) - Claim must be submitted by the provider who rendered the service. |
| N40 | (Modified 6/30/03) - Missing/incomplete/invalid x-ray. |
| N69 | (Modified 6/30/03) - PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies. |
| N71 | (Modified 6/30/03) - Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims. |
| N72 | (Modified 6/30/03) - PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records. |
| N100 | (Modified 6/30/03) - PPS (Prospect Payment System) code corrected during adjudication. |
| N103 | (Modified 6/30/03) - Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt. |
| N106 | (Modified 6/30/03) - Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service. |
| N107 | (Modified 6/30/03) - Services furnished to skilled nursing facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services. |
| N113 | (Modified 6/30/03) - Only one initial visit is covered per physician, group practice or provider. |
| N115 | (Modified 6/30/03) - This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at ***www.cms.hhs.gov/mcd***, or if you do not have web access, you may contact the contractor to request a copy of the LMRP. |
| N117 | (Modified 6/30/03) - This service is paid only once in a patient's lifetime. |
| N119 | (Modified 6/30/03) - This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or skilled nursing facility (SNF) within those 28 days. |
| N120 | (Modified 6/30/03) - Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/ readmitted during payment episode. |

| Code | (Modification Date) - Current Modified Narrative |
|---|---|
| N121 | (Modified 6/30/03) - No coverage for items or services provided by this type of practitioner for patients in a covered skilled nursing facility (SNF) stay. |
| N177 | (New Code 2/28/03; Modified 6/30/03) - We did not send this claim to patient's other insurer. They have indicated no additional payment can be made. |

### Deactivated Remark Codes:

| Code | (Deactivation Date) - Current Modified Narrative |
|---|---|
| M43 | (Deactiv. eff. 1/31/04; Refer to Reason Code 23) - Payment for this service previously issued to you or another provider by another carrier/intermediary. |
| M48 | (Deactiv. eff. 1/31/04; Refer to M97) - Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service. |
| M63 | (Deactiv. eff. 1/31/04; Refer to M86) - We do not pay for more than one of these on the same day. |
| M98 | (Deactiv. eff.1/31/04; Refer to M99) - Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN. |
| M101 | (Deactiv. eff. 1/31/04; Refer to M78) - Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier. |
| M106 | (Deactiv. eff. 1/31/04; Refer to MA31) - Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service. |
| M140 | (Deactiv. eff. 1/31/04; Refer to M82) - Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday. |
| MA11 | (Deactiv. eff. 1/31/04; Refer to M32) - Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Contact us if the patient is covered by any of these sources. |
| MA78 | (Deactiv. eff. 1/31/04; Refer to MA59) - The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient. |
| MA104 | (Deactiv. eff. 1/31/04; Refer to M128 or M57) - Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician. |
| MA124 | (Deactiv. eff. 1/31/04; Refer to reason code 74) - Processed for IME only. |
| MA129 | (Deactiv. eff. 1/31/04; Refer to MA120 and reason code B7) - This provider was not certified for this procedure on this date of service. |
| N18 | (Deactiv. eff. 1/31/04; Refer to N14) - Payment based on the Medicare allowed amount. |
| N60 | (Deactiv. eff. 1/31/04; Refer to M119) - A valid NDC is required for payment of drug claims effective October 02. |
| N73 | (Deactiv. eff. 1/31/04; Refer to MA101 or N200) - A skilled nursing facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents. |
| N101 | (Deactiv. eff. 1/31/04; Refer to MA105) - Additional information is needed in order to process this claim. Resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim. |
| N164 | (Deactiv. eff. 1/31/04; Refer to N157) - Transportation to/from this destination is not covered. |
| N165 | (Deactiv. eff. 1/31/04; Refer to N158) - Transportation in a vehicle other than an ambulance is not covered. |
| N166 | (Deactiv. eff. 1/31/04; Refer to N159) - Payment denied/reduced because mileage is not covered when the patient is not in the ambulance. |
| N168 | (Deactiv. eff. 1/31/04; Refer to N160) - The patient must choose an option before a payment can be made for this procedure/equipment/supply/service. |
| N169 | (Deactiv. eff. 1/31/04; Refer to N161) - This drug/service/supply is covered only when the associated service is covered. |

## X12N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted, three times a year after each X12 trimester meeting, at ***www.wpc-edi.com/codes/Codes.asp*** (select "Claim Adjustment Reason Codes" from the pull down menu to view list). All reason code changes approved in June 2003 are listed here.

### Reason Code Changes (as of 6/30/03):

| Code | (Notes) - Current Narrative |
|---|---|
| 155 | (New as of 6/03) - This claim is denied because the patient refused the service/procedure. |
| 38 | (Modified as of 6/03) - Services not provided or authorized by designated (network/primary care) providers. |
| 107 | (Modified as of 6/03) - Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim. |

The following is a comprehensive list of retired reason codes. Codes retired effective version 4010 or any previous version is bolded.

| Code | (Notes) - Current Narrative |
|---|---|
| **28** | **(Inactive for 004010, since 6/98. Redundant to codes 26&27.) - Coverage not in effect at the time the service was provided.** |
| **36** | **(Inactive for 003040) - Balance does not exceed co-payment amount.** |
| **37** | **(Inactive for 003040) - Balance does not exceed deductible.** |
| **41** | **(Inactive for 003040) - Discount agreed to in Preferred Provider contract.** |
| **46** | **(Inactive for 004010, since 6/00. Use code 96.) - This (these) service(s) is (are) not covered.** |
| **48** | **(Inactive for 004010, since 6/00. Use code 96.) - This (these) procedure(s) is (are) not covered.** |
| 57 | (Inactive for 004050. Split into codes 150, 151, 152, 153 and 154.) - Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. |
| **63** | **(Inactive for 003040) - Correction to a prior claim.** |
| **64** | **(Inactive for 003040) - Denial reversed per medical review.** |
| **65** | **(Inactive for 003040) - Procedure code was incorrect. This payment reflects the correct code.** |
| **67** | **(Inactive for 003040) - Lifetime reserve days. (Handled in QTY, QTY01=LA)** |
| **68** | **(Inactive for 003040) - DRG weight. (Handled in CLP12)** |
| **71** | **(Deleted as of 6/00. Use code 23.) - Primary payer amount.** |
| **72** | **(Inactive for 003040) - Coinsurance day. (Handled in QTY, QTY01=CD)** |
| **73** | **(Inactive for 003050) - Administrative days.** |
| **77** | **(Inactive for 003040) - Covered days. (Handled in QTY, QTY01=CA)** |
| **79** | **(Inactive for 003050) - Cost Report days. (Handled in MIA15)** |
| **80** | **(Inactive for 003050) - Outlier days. (Handled in QTY, QTY01=OU)** |
| **81** | **(Inactive for 003040) - Discharges.** |
| **82** | **(Inactive for 003040) - PIP days.** |
| **83** | **(Inactive for 003040) - Total visits.** |
| **84** | **(Inactive for 003050) - Capital Adjustment. (Handled in MIA)** |
| **86** | **(Inactive for 004010, since 6/98. Duplicative of code 45.) - Statutory Adjustment.** |
| 88 | (Inactive for 004050.) - Adjustment amount represents collection against receivable created in prior overpayment. |
| **92** | **(Inactive for 003040) - Claim paid in full.** |
| **93** | **(Inactive for 004010, since 2/99. In 004010, CAS at the claim level is optional.) - No claim level adjustments.** |
| **98** | **(Inactive for 003040) - The hospital must file the Medicare claim for this inpatient non-physician service.** |
| **99** | **(Inactive for 003040) - Medicare Secondary Payer Adjustment Amount.** |
| 120 | (Inactive for 004030) - Patient is covered by a managed care plan. |
| 123 | (Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.) - Payer refund due to overpayment. |
| 124 | (Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.) - Payer refund amount - not our patient. |
| **A3** | **(Inactive for 004010, since 6/98.) - Medicare Secondary Payer liability met.** |
| **B2** | **(Inactive for 003040) - Covered visits.** |
| **B3** | **(Inactive for 003040) - Covered charges.** |
| **B19** | **(Inactive for 003070) - Claim/service adjusted because of the finding of a Review Organization.** |
| **B21** | **(Inactive for 003040) - The charges were reduced because the service/care was partially furnished by another physician.** |
| **D1** | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim/service denied. Level of subluxation is missing or inadequate.** |
| **D2** | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim lacks the name, strength, or dosage of the drug furnished.** |

| Code | (Notes) - Current Narrative |
|---|---|
| D3 | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.** |
| D4 | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim/service does not indicate the period of time for which this will be needed.** |
| D5 | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim/service denied. Claim lacks individual lab codes included in the test.** |
| D6 | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim/service denied. Claim did not include patient's medical record for the service.** |
| D7 | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim/service denied. Claim lacks date of patient's most recent physician visit.** |
| D8 | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim/service denied. Claim lacks indicator that `x-ray is available for review.** |
| D9 | **(Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.) - Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.** |
| D10 | **(Inactive for 003070, since 8/97. Use code 17.) - Claim/service denied. Completed physician financial relationship form not on file.** |
| D11 | **(Inactive for 003070, since 8/97. Use code 17.) - Claim lacks completed pacemaker registration form.** |
| D12 | **(Inactive for 003070, since 8/97. Use code 17.) - Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.** |
| D13 | **(Inactive for 003070, since 8/97. Use code 17.) - Claim/service denied. Performed by a facility/ supplier in which the ordering/referring physician has a financial interest.** |
| D14 | **(Inactive for 003070, since 8/97. Use code 17.) - Claim lacks indication that plan of treatment is on file.** |
| D15 | **(Inactive for 003070, since 8/97. Use code 17.) - Claim lacks indication that service was supervised or evaluated by a physician.** |

The updated codes will be used in remittance advices (electronic and paper) **effective January 1, 2004**.

[Reference: Change Request (CR) 2975; Transmittal 32]

# Revised ANSI X12N 837 Professional Health Care Claim Companion Document

A companion document is defined as a set of statements, which supplements the American National Standards Institute (ANSI) X12N 837 Professional Implementation Guide and clarifies the contractor expectations regarding data submission, processing, and adjudication. A revised 837 Professional companion document is provided due to errors and omissions in the previous companion document as well as changes in the implementation guide.

The Region A Durable Medical Equipment Regional Carrier (DMERC A) updated its companion document on January 20, 2004. To access this document:

- Visit ***www.umd.nycpic.com/edidocfiles.html***
- Scroll down to "Files"
- Click on "Region A DMERC Companion Document/Trading Partner Agreement"

[Reference: Change Request (CR) 2900; Transmittal 29]

# ExpressPlus Users Update

Occasionally, upgrades are necessary to enhance features or resolve issues with our software. The easiest, fastest, and most economical way to do this is to make downloads available via the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site. To ensure that you are using the latest version of ExpressPlus, please visit our Web site periodically to see if an upgrade has been issued. You may access the "HIPAA Compliant Software" section of our Web site directly at ***www.umd.nycpic.com/edisoftware.html*** and click on "Upgrades." (Note: A ListServe message is sent to notify subscribers of the availability of the upgrade on our Web site. Please see the article on page 25 for details on how to subscribe.)

# EDI Change Form

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department encourages all electronic submitters

to keep your information updated with DMERC A. If for any reason any of the below information changes, please make sure EDI is notified in a timely manner. You may fax this form to 570-735-9510. The EDI Department strives to keep our records accurate, so we may continue to assist our electronic submitters and provide a high level of customer service.

**Electronic Data Interchange (EDI) Change Form**

Submit this form to EDI if you are changing any of the following information:

***Submitter Number**: _____

NSC Number: _____

***Company Name**:

_____

Address: _____

_____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

Contact Person: _____

Email: _____

Software Vendor:

_____

Billing Service:

_____

*** Required field**

(Note: NSC stands for National Supplier Clearinghouse)

# Electronic Submission of Medicare Claims

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L. 107-105, and the implementing regulation at 42 CFR 424.32 require that **all initial claims** for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions. **(Note: The Health Insurance Portability and Accountability Act (HIPAA) requires that clearinghouses submit claims electronically effective October 16, 2003, without exception.)**

To read the requirements based on ASCA, visit the "EDI & HIPAA - Resources" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site (***www.umd.nycpic.com/emc&hipaa.html***) and follow the Portable Document Format (PDF) instructions for "Electronic Submission of Medicare Claims." When visiting the DMERC A Web site, view detailed information concerning the electronic products and services offered for providers that need electronic software capabilities.

[Reference: Change Request (CR) 2966; Transmittal 44]

# Provider Information Related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The following information has been provided by the Centers for Medicare & Medicaid Services (CMS) to assist providers with issues related to 837 inbound claims and remittance advice 835 transactions.

## Common Medicare Submitter Claim Testing Problems

Listed below is a list of technical and non-technical issues that Medicare contractors have encountered that are preventing submitters from moving into production on the 837 claim:

1. Errors in data element **NM109**

   Submitters are placing the Medicare provider number or

UPIN in NM109 instead of the REF (secondary identification number) segment.

**CMS Guidance:** NM109 must contain the provider SSN or EIN. Medicare provider numbers must be submitted in the REF02 with the appropriate qualifier in REF01 (1C for Medicare provider number or 1G for the Medicare UPIN).

2. Enveloping issues – **ISA and GS** segments
   - GS02 and 03 – invalid submitter codes and receiver codes
   - ISA06 and 08 – contractor codes are being omitted
   - Invalid lengths in the data elements contained in the envelopes
   - ISA15 contains the value "P" when testing

   **CMS Guidance:** ISA06 and GS02 must contain the submitter code that is agreed to or assigned by the Medicare contractor. ISA08 and GS03 must contain the Medicare contractor receiver number.

   The ISA and ISE are fixed length segments. The length defined in the implementation guide must be followed.

   When testing, the ISA15 must have a value of "T."

3. Invalid taxonomy codes

   **CMS Guidance:** Although CMS does not require a taxonomy code, it must be a valid code if submitted. A list of the approved codes is posted at the Washington Publishing Company (WPC) Web site at ***www.wpc-edi.com/codes***.

4. Invalid characters in the data stream

   **CMS Guidance:** The basic character set as defined in Appendix A of the 837 implementation guide must be used. In addition, certain characters from the extended character set may be used. Contact your Medicare contractor for a copy of their companion document for further guidance. (Note: The Region A Durable Medical Equipment Regional Carrier (DMERC A) companion document is available via our Web site at ***www.umd.nycpic.com/edidocfiles.html***.)

5. **SBR** (subscriber) data elements missing, such as date of birth and gender. **SBR09** identifies the incorrect payer.

   **CMS Guidance:** SBR09 must equal "MB" for Medicare Part B or "MA" for Medicare Part A. All required data elements in the SBR segment must be submitted per the implementation guide.

6. Missing/out of order **N3** and **N4** segments

   **CMS Guidance:** When address information is submitted, the N3 (street address information) and N4 (city, state, and zip code information) must be submitted. State codes and zip codes must be valid codes based on the code source in the 837 implementation guide.

7. Submitter's contact phone number missing

   **CMS Guidance:** Loop 1000A is always required. The submitter's communications number (fax, email, telephone, etc.) must be provided in this loop. (Note: This information is submitted as ten (10) numeric digits without hyphens, parentheses, or spaces.)

8. Sending both billing provider loop and rendering provider loop when they are the same entity.

   **CMS Guidance:** When the billing provider is the same as the rendering provider, loop 2310B is not submitted. In this case the rendering provider is identified in loop 2000A.

9. Invalid date formats

   **CMS Guidance:** When dates are submitted, they must be formatted in accordance with the value in DTP02.

In addition, the following information provides guidance related to inbound claims and Medicare's contingency plan for HIPAA:

- New electronic submitters may **only** test on the HIPAA format;
- New electronic submitters may **only** go into production on the HIPAA format; and
- Current electronic submitters may not begin testing or submitting inbound claims for any new providers in other than the HIPAA-compliant format.

Listed below are the data elements on the HIPAA X12N 837 institutional and professional health care claim forms that are required, but were not previously

required on the electronic Part A (UB92) formats and Medicare Part B (National Standard Format):

**Part A 837:**

- X12 837i transaction overhead information (ST, BHT, Transmission Type REF, HLs, and SE segments, along with numerous qualifiers)
- Submitter Identifier (837 overhead info)
- Receiver Name
- Receiver Identifier
- Billing Provider Tax Identification Number or Social Security Number
  (Note: One of the following is required
  - Attending Physician Tax Identification Number or Social Security Number
  - Operating Physician Tax Identification Number or Social Security Number
  - Other Provider Tax Identification Number or Social Security Number)
- Payer Identifier
- Explanation of Benefits Indicator
- Provider or Supplier Signature Indicator

**Part B 837:**

- Receiver name and ID
- Submitter Name
- Submitter Phone Number
- Billing Provider Tax Identification Number or Social Security Number
- Pay-To Provider Tax Identification Number or Social Security Number
- Rendering Provider Tax Identification Number or Social Security Number
- Admission Date for inpatient medical visits

In addition, the following information provides guidance related to remittance advices and Medicare's contingency plan for HIPAA:

- New electronic remittance receivers may **only** test and go into production on the HIPAA format; and
- Any entity (e.g., clearinghouse) currently receiving electronic remittance advice may **not** add a new provider receiving remittance advice in a pre-HIPAA format.

## Updated NCPDP Companion Document

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

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

[Reference: Change Request (CR) 2964; Transmittal 48]

## Important: Added Documentation Reminder

Since the implementation of the Health Insurance Portability and Accountability Act (HIPAA), there has been an increase in the quantity of added documentation being faxed and mailed to the Region A Durable Medical Equipment Regional Carrier (DMERC A). This is partially due to the size reduction in the data elements in the HIPAA-compliant electronic formats (ANSI NTE 2400 and NCPDP 498-PP). The data elements were reduced to holding only 80 characters for additional documentation notations.

In order to help decrease the quantity of added documentation that is faxed and mailed, DMERC A has developed a "suggested list" of abbreviations. This suggested list, which is available via the DMERC A Web site at ***www.umd.nycpic.com/edidocfiles.html***, can be used in order to maximize the effectiveness of the reduced space within these new elements and to fit more information in the HIPAA-compliant electronic formats.

When an Advanced Determination of Medicare Coverage (ADMC) is approved for payment, the additional medical documentation or Certificate of Medical Necessity (CMN) does **not** need to be submitted again with the initial claim or as additional documentation. (Note: Items billed using Healthcare Commom Procedure Coding System (HCPCS) code K0108 require a narrative description, brand name, and model name/number for the item, even when approved through ADMC. Suppliers must ensure the narrative description on the claim matches the narrative description used on the ADMC determination letter.) For further information on the ADMC process, please refer to Chapter 9 (Durable Medical Equipment) of the *DMERC A Supplier Manual*, which can be accessed via our Web site at ***www.umd.nycpic.com/dmprovpublcopy.html***.

An CMN is **not** considered additional documentation. CMNs should be submitted in hardcopy with CMS-1500 forms or via the electronic equivalent. Refer to the individual medical policies for specific documentation provisions regarding CMNs.

DMERC A has also seen an increase in duplicate submission of additional documentation for items that do not require this information with each claim billed (e.g., wheelchairs and parenteral/enteral nutrition). A copy of the original documentation should be submitted, via fax or mail, to DMERC A **one time only**. Submission each month is not necessary and may cause delays in claims processing for these items. Added documentation should only be sent when required by the medical policy. The medical policies for Region A are available on the Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/lmrp_current_dyn.cfm***.

A cover sheet **must** be used when sending additional documentation to DMERC A. The cover sheet can be obtained via our Web site at ***www.umd.nycpic.com/extra.html***. The cover sheet needs to be completed accurately, with the appropriate date of service (DOS) for the claim. There is no guarantee the additional documentation will be matched with the appropriate claim when the DOS is different.

Suppliers should **only** fax added documentation one time **and** should check their transmission report for any failed attempts. Suppliers that consistently send added documentation more than once per claim will be contacted for education. Remember, decreasing the amount of unnecessary added documentation would speed up claims processing for everyone.

# Miscellaneous

## Appeals Analysis Update

The Region A Durable Medical Equipment Regional Carrier (DMERC A) performs analysis of appeal cases on a monthly basis. Appeal cases are reviewed to determine issues such as the top Healthcare Common Procedure Coding System (HCPCS) codes submitted for an appeal along with their outcome, suppliers with high reversal rates, and system or processing errors. For each issue identified, the appropriate action is taken, whether it be provider education, review of internal processes, policy changes, or system enhancements. Through this effort, we can avoid unnecessary denials on initial claims and significantly decrease the number of reviews at all levels. This will ensure prompt and correct initial claim payment and eliminate unnecessary effort for both the supplier community and DMERC A.

Our recent analysis confirmed a high reversal rate at the review level for oxygen codes. Random samples were obtained for the time period October 2003 - December 2003. It was determined that the highest reversal reasons were either the Certificate of Medical Necessity (CMN) was not on file at DMERC A to warrant payment for the date(s) of service billed, or the CMN was incorrect when submitted, then corrected and resubmitted upon review. Approximately 88 percent of the reversals for oxygen were CMN-related.

The oxygen policy, located on the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/lmrp_current_dyn.cfm***, outlines the appropriate coverage and payment rules for oxygen, and its equipment, and provides information as to the appropriate submission of CMNs. The documentation section of the policy specifies when an initial, recertification, or revised CMN is required for submission. Providers without Internet access can

request a copy of the policy by calling the DMERC A supplier toll-free line at 866-419-9458, or by writing to:

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

Program Inquiries works with Program Education & Training on provider education issues, and one of the results of the recent analysis is the "Respiratory Billing" seminar being offered in the spring of 2004 (see the article on page 23 for details).

## Provider Alert: Stopping Abuse of the Power Wheelchair Benefit

Medicare providers need to be aware of new efforts recently announced by the Centers for Medicare & Medicaid Services (CMS) that are aimed at stopping abuse of the power wheelchair benefit in the Medicare Program. CMS will be taking immediate action to substantially curb abuse by unscrupulous providers who prey on Medicare beneficiaries. In addition, the Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) is investigating the proliferation of durable medical equipment (DME) fraud cases involving inflated billings to Medicare, charges for equipment and supplies not delivered, and the falsification of documents to qualify beneficiaries for wheelchairs and other equipment that they often do not need.

CMS will begin aggressively reviewing applications from companies that seek to provide power wheelchairs to ensure that they meet reputable business standards of operation. CMS will also review its supplier enrollment standards, increase efforts to educate physicians and beneficiaries about the wheelchair benefit, and enhance current coverage and medical review policies to ensure that Medicare pays for wheelchairs when they are absolutely necessary.

Listed below are some of the immediate efforts that CMS is undertaking to stop the widespread and systemic fraud of this benefit:

- To prevent fraudulent suppliers from enrolling with Medicare for the sole purpose of receiving inappropriate payments, CMS will immediately begin aggressively scrutinizing all new applications for supplier numbers. Because of this increased scrutiny, new supplier numbers will not be issued until early 2004.
- CMS will be publishing regulations that will enhance the ability to screen new supplier applications to identify and prevent inappropriate enrollment of suppliers by providing a more detailed screening process, allowing CMS the time needed to properly review applications, and to provide sanctions against suppliers abusing the enrollment process.
- To quickly identify and punish fraudulent suppliers, CMS, Durable Medical Equipment Regional Carriers (DMERCs), and law enforcement agencies will collaborate to process fraud cases and assure aggressive, timely application of sanctions, and civil or criminal prosecutions. CMS will exercise one of its strongest administrative tools, payment suspensions, to stop the improper hemorrhaging of Medicare dollars.

CMS will finalize regulations revising coverage policy for motorized wheelchairs and scooters to assure that national policy accurately defines the conditions under which Medicare will cover mobility products. This policy will require, for the first time, that a medical provider see the patient before prescribing a wheelchair or scooter. This policy will allow the medical provider to prescribe either a motorized wheelchair or a power-operated vehicle (POV). Under existing policy, only a specialist may prescribe a POV.

- DMERCs will adopt Local Medical Review Policies (LMRPs) that accurately portray the clinical conditions for which mobility products are reasonable and necessary. This will educate suppliers and beneficiaries on when wheelchairs will be paid for by Medicare and will facilitate correct billing and payment for mobility products.
- DMERCs will also adopt a consistent approach to medical review so that when national billing and utilization trends are identified, Medicare knows that only claims that are reasonable and necessary are paid and that national billing problems are resolved in a consistent manner.
- CMS will work with physicians to clarify their prescribing responsibilities and Medicare coverage criteria.

A brochure titled ***'Medicare Coverage of Power Wheelchairs and Other Power Operated Vehicles'*** that outlines the current Medicare coverage information can be viewed on the Medlearn Web site at: ***www.cms.hhs.gov/medlearn/PowerWheelchair.pdf***.

[Reference: Change Request (CR) 2986; Transmittal 2]

# Clarification of Proof of Delivery Requirements

One of the requirements for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as described below, requires suppliers to maintain a proof of delivery for DMEPOS items provided to Medicare beneficiaries. This information is only made available to the Durable Medical Equipment Regional Carriers (DMERCs) upon request as supportive documentation and is not included in the processing of claims.

## Supplier Proof of Delivery Documentation Requirements

Suppliers are required to maintain proof of delivery documentation in their files. Documentation must be maintained in the supplier's files for seven (7) years.

Proof of delivery is required in order to verify that the beneficiary received the DMEPOS. Proof of delivery is one of the supplier standards as noted in 42 CFR 424.57(12). Proof of delivery documentation must be made available to the DMERC upon request. For any services, which do not have proof of delivery from the supplier, such claimed items and services shall be denied and overpayments recovered. Suppliers who consistently do not provide documentation to support their services may be referred to the Office of the Inspector General (OIG) for investigation and/or imposition of sanctions.

## Proof of Delivery and Delivery Methods

For the purpose of the delivery methods noted below, **designee** is defined as:

> "Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

Suppliers may deliver directly to the beneficiary or the designee. An example of proof of delivery to a beneficiary is having a signed delivery slip, and it is recommended that the delivery slip include:

1) The patient's name;
2) The quantity delivered;
3) A detailed description of the item being delivered;
4) The brand name; and
5) The serial number.

(The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee.)

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary should be noted on the delivery slip obtained by the supplier (i.e., spouse, neighbor, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier should note the name of the designee on the delivery slip.

If the supplier utilizes a delivery/shipping service, an example of proof of delivery would include the delivery service's tracking slip, and the supplier's own shipping invoice. If possible, the supplier's records should also include the delivery service's package identification number for that package sent to the beneficiary. The delivery service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the delivery service, and if possible, the date delivered. If a supplier utilizes a delivery/shipping service or mail order that is able to provide the actual date of receipt by the beneficiary or designee, such date shall be considered the date of service on the claim. When the date of actual delivery is not provided, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery. The descriptive information concerning the DMEPOS item (i.e., the patient's name, the quantity, detailed description, brand name, and serial number) as well as the required signatures from either the beneficiary or the beneficiary's designee should be included on this invoice as well.

The start of usage by the beneficiary of the DMEPOS item is signaled by the initial delivery date of the item found on the delivery slip. Claims filed by the supplier should reflect the initial delivery date noted on the delivery slip and shall not claim dates of service prior to delivery. For initial DMEPOS products delivered to

a beneficiary residing in a nursing facility, the initial date of service on the claim is to be the date the item(s) was provided to the beneficiary at the nursing facility. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills should take place no sooner than seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than five (5) days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. The date of service on the claim for refills should be the start date of the "new" usage period and should not overlap the previous usage date. Suppliers should file such claims on or after the beginning of the new usage period.

For those patients that are residents of a nursing facility, suppliers should obtain copies of the necessary documentation from the nursing facility to document proof of delivery or via the documentation requirements dictated by the delivery method.

### Exceptions

Exceptions to the preceding statements concerning the date(s) of service on the claim occur when the items are provided in anticipation of discharge from a hospital or nursing facility. A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two (2) days prior to the patient's discharge to their home. The supplier should bill the date of service on the claim as the date of discharge and should use the place of service (POS) as 12 (patient's home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

A supplier may not bill for drugs or other DMEPOS items used by the patient prior to the patient's discharge from the hospital or a Medicare Part A nursing facility stay. Billing the DMERC for surgical dressings, urological supplies, or ostomy supplies that are provided in the hospital or during a Medicare Part A nursing facility stay is not allowed. These items are payable to the facility under Part A of Medicare. This prohibition applies even if the item is worn home by the patient from the hospital or nursing facility. Any attempt by the supplier and/or facility to substitute an item that is payable to the supplier for an item that, under statute, should be provided by the facility, may be considered to be fraudulent. These statements apply to durable medical equipment delivered to a patient in hospitals, skilled nursing facilities (POS = 31), or nursing facilities providing skilled services (POS = 32).

Chapter 9 (Durable Medical Equipment) of the *DMERC A Supplier Manual* has been updated to reflect the above information. For additional information on proof of delivery, please refer to the "What's New" section of the Region A Program Safeguard Contractor (PSC) Web site at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

[Reference: Change Request (CR) 2903; Transmittal 61]

## 2004 Region A DMERC Fee Schedule and First Quarter 2004 Fee Updates

The Region A Durable Medical Equipment Regional Carrier (DMERC A) posts new and updated fees to the "Fee Schedules" section of our Web site at ***www.umd.nycpic.com/dmfees.html***. In addition to the 2004 Region A DMERC Fee Schedule, the following fees have been posted for the first quarter 2004:

- 2004 Fee Schedule Article/Information (see article that follows)
- 1st Quarter 2004 Update: Drug Fees
- 1st Quarter 2004 Update: Oral Anticancer Drug Fees
- 2004 National Payment Limits for Therapeutic Shoes (see article that follows)

Claims for items furnished on or after January 1, 2004, will be paid in accordance with the amounts for calendar year 2004. **Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.**

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

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

[References: Change Request (CR) 2957, Transmittal 17; CR 3013, Transmittal 31]

# 2004 Fee Schedule Article/Information

### Incorrect Fees: E0301 and E0302

It has come to the attention of DMERC A that the fees for two new Healthcare Common Procedure Coding System (HCPCS) codes for 2004 are incorrect. The incorrect fees are for E0301 (Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 lbs., but less than or equal to 600 lbs., with any type side rails, without mattress) and E0302 (Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 lbs., with any type side rails, without mattress). These two codes will be gap-filled by DMERC A until April 2004, when the correct fee schedule amounts will become effective.

### Update: J7621 Fee

Code J7621 (Albuterol, all formulations, including separated isomers) was previously listed under the 2004 nebulizer drug fees as an individual consideration (IC) code. Subsequently, a fee of $3.40 has been established for this code for 2004.

### Important: A4366 Fee Schedule Amounts

The previously published 2004 fee schedule amounts for new code A4366 (ostomy vent, any type, each) were calculated using an incorrect factor. This code will be gap-filled until April 2004, when the correct fee schedule amounts will become effective.

### L0486 Fee Schedule Amounts

The fee schedule amounts for code L0486 are being revised as part of the January 2004 DMEPOS fee schedule update.

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

[References: Change Request (CR) 2957, Transmittal 17; CR 3013, Transmittal 31; CR 3020, Transmittal 35; CR 3025, Transmittal 55]

# 2004 National Payment Limits for Therapeutic Shoes

Listed below are the National Payment Limits for Therapeutic Shoes under the Standard Reasonable Charge Rules. These limits apply to codes **A5500 - A5501 and A5503 - A5511 and are priced per single shoe/insert/modification**. Reasonable charge fees are established for each state. However, the maximum allowable amount for each code cannot exceed the cap amount. The current cap breakdown for 2004, which is the same for all states, is as follows:

| Code | Ceiling |
|---|---|
| A5500 | $66.00 |
| A5501 | $198.00 |
| A5503 | $33.50 |
| A5504 | $33.50 |
| A5505 | $33.50 |
| A5506 | $33.50 |
| A5509 | $33.50 |
| A5510 | $33.50 |
| A5511 | $33.50 |

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

[Reference: Change Request (CR) 3013; Transmittal 31]

# April Quarterly Update for 2004 DMEPOS Fee Schedule

The durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly updates process for the DMEPOS fee schedule is located in Section 60 of Chapter 23 of the Medicare Claims Processing Manual (Pub 100-4).

Effective April 1, 2004, the following new Healthcare Common Procedure Coding System (HCPCS) codes will be processed for claims submitted to the Region A Durable Medical Equipment Regional Carrier:

| | | | | | |
|---|---|---|---|---|---|
| K0627 | K0628 | K0629 | K0630 | K0631 | K0632 |
| K0633 | K0634 | K0635 | K0636 | K0637 | K0638 |
| K0639 | K0640 | K0641 | K0642 | K0643 | K0644 |
| K0645 | K0646 | K0647 | K0648 | K0649 | |

For more information on the new HCPCS codes, refer to the "What's New " section of the Region A Program Safeguard Contractor (PSC) Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm***.

Information regarding fee schedules amounts will be communicated at a later date in a separate publication.

[Reference: Change Request (CR) 3014; Transmittal 58]

# Program Education & Training

## Claim Submission Errors for the First 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 November and December 2003, are provided in the following chart. The total number of ANSI errors for this period was **135,879**.

| ANSI Error (Total) | Corrective Action |
|---|---|
| **1)** Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question (27,376 errors) | The question number entered is not valid for the DMERC CMN you are sending. |
| **2)** Procedure Code/ Modifier Invalid (14,529 errors) | The procedure code and/or modifier used on this line is invalid. |
| **3)** Dates of Service Exceed Master Procedure Record (MPR) Dates (4,804 errors) | The procedure code used is not valid for the dates of service used. |
| **4)** Invalid/Unnecessary CMN Version Submitted (4,604 errors) | The DMERC CMN version number entered is not valid for the Healthcare Common Procedure Coding System (HCPCS) code submitted. |
| **5)** Invalid/Unnecessary CMN Submitted (4,573 errors) | The DMERC CMN form number entered is not valid for the HCPCS code submitted. |
| **6)** ID Code Qualifier Invalid (4,404 errors) | The qualifier identifiying the referring provider identification number for this claim is invalid. |
| **7)** Other Payor ID Code Qualifier Invalid (4,404 errors) | The qualifier identifying the other payer identification number for this claim is invalid. |
| **8)** Service "From" Date Does Not Equal "To" Date (3,792 errors) | The procedure code submitted for this line does not allow for spanned dates of service. |
| **9)** Subscriber ID Code Invalid (3,400 errors) | The qualifier identifying the subscriber identification number is invalid. |
| **10)** Invalid Carrier Code (3,150 errors) | The carrier code is incorrect for DMERC A. |

In an effort to reduce all claim denials, DMERC A is including the top ten return/reject denials for the first quarter of fiscal year 2004. When claims are denied in this manner, they are considered to be unprocessable. 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, on the Centers for Medicare & Medicaid Services (CMS) Web site at ***www.cms.hhs.gov/manuals/***.)

Providers will need to correct or add the necessary information and resubmit the claim as they would a new claim. **No appeal rights are afforded to return/reject denials.**

| Return/Reject Denial (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. (23,616 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 (primary, secondary condition). |

| Return/Reject Denial (Total Claims Denied) | CMS-1500 Form Entry Requirement |
|---|---|
| **2) CO 16 M51** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. Missing/incomplete/invalid procedure codes(s) and/or rates. (15,867 claims) | **Item 24D** -Enter the procedures, services, or supplies using the HCPCS. When applicable, show HCPCS modifiers with the HCPCS code. |
| **3) CO 16 M78** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. Missing/incomplete/invalid HCPCS modifier. (11,385 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 102** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider (6,640 claims) | **Item 17** -Enter the name of the referring or ordering physician.<br><br>*AND/OR*<br><br>**Item 17A** - Enter the Unique Physician Identification Number (UPIN). |
| **5) CO 16 MA 83** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. Did not indicate whether we are the primary or secondary payer. (6,323 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." |
| **6) CO 16 M77** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. Missing/incomplete/invalid place of service. (5,086 claims) | **Item 24B** - Enter the appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed. |
| **7) CO 16 N64** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. The "from" and "to" dates must be different. (4,805 claims) | **Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A. |
| **8) CO 16 MA82** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number. (4,471 claims) | **Item 33** - Enter the provider of service/supplier's billing name, address, zip code, and telephone number. Enter the Physician Identification 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. |
| **9) CO 16 M53** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. Missing/incomplete/invalid days or units of service. (1,884 claims) | **Item 24G** - Enter the number of days or units. |
| **10) CO 16 M79** - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. Missing/incomplete/invalid charge. (548 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 each claim (electronic and paper). DMERC A will continue to furnish information to assist providers in reducing these errors and increasing claims processing efficiency.

# Spring 2004 Seminars

The Region A Durable Medical Equipment Regional Carrier (DMERC A) announces the spring 2004 continuing education seminars and workshops. These sessions are being offered at **no charge**. Topics for the sessions include DMERC 101/Documentation, Medicare Program Billing Updates, Respiratory Billing, and Parenteral/Enteral Nutrition Billing. The seminars are being offered as two-day sessions, however, you may attend any session(s) you wish. Please visit the "Events" section of the DMERC A Web site (***www.umd.nycpic.com/dmprovcaln.html***) for detailed information.

## Dates and Locations

| Date | Location/ Telephone | Address |
|---|---|---|
| April 13-14, 2004 | Wyndham Hotel Wilmington 302-655-0400 | 700 King Street Wilmington, DE 19801 |
| April 20-21, 2004 | Sheraton Parsippany Hotel 973-515-2000 | 199 Smith Road Parsippany, NJ 07054 |
| April 27-28, 2004 | Radisson Hotel Pittsburgh 412-373-7300 | 10 Mall Boulevard Monroeville, PA 15146 |
| May 4-5, 2004 | Four Points by Sheraton 716-681-2400 | 2040 Walden Avenue Buffalo, NY 14225 |
| May 17-18, 2004 | Sheraton Springfield 413-263-2051 | One Monarch Place Springfield, MA 01144 |
| May 20-21, 2004 | "The Yard" - Adjacent to the Best Western Executive Court Inn & Conference Center 603-623-3545 | Mammoth Road & South Willow Street Manchester, NH 03109 |

**Day-One Seminar Agenda:**

| | |
|---|---|
| 8:30 AM - 9:00 AM | Registration for morning session |
| 9:00 AM - 1:00 PM | DMERC 101/Documentation |
| 1:30 PM - 2:00 PM | Registration for afternoon session |
| 2:00 PM - 5:00 PM | Medicare Billing Updates |

**Day-Two Seminar Agenda:**

| | |
|---|---|
| 8:30 AM - 9:00 AM | Registration for morning session |
| 9:00 AM - 12:00 PM | Respiratory Billing (Please Note: This session does **not** include Nebulizer Billing.) |
| 12:30 PM - 1:00 PM | Registration for afternoon session |
| 1:00 PM - 4:00 PM | Parenteral/Enteral Nutrition (PEN) Billing |

## How to Register

All attendees ***must*** be registered in advance. **You may now submit your registration online.** The registration form is available via the "Events" section of our Web site. **Registrations are due *no later than one week* prior to the seminar.** If you do not have Internet access, please call 570-735-9666, Option 1, and **leave your name, company name, telephone number, and fax number**, and a registration form will be faxed to you.

Due to limited space, registration is on a first come, first served basis. In the event that a particular session is filled to capacity, you will be notified by telephone. DMERC A reserves the right to cancel any seminar. If this occurs, you will be notified.

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

# Provider Communications (PCOM) Advisory Group

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department encourages interested

representatives to become a member of the PCOM Advisory Group. It is important to ensure our targeted educational efforts are both meaningful and helpful to the provider community as a whole, and members of this group play a vital role in accomplishing this task.

The first quarterly meeting for fiscal year 2004 was held at the Renaissance Philadelphia Hotel Airport on November 12, 2003. Participants included representatives from the Centers for Medicare & Medicaid Services (CMS), TriCenturion, LLC, the Program Safeguard Contractor (PSC) for Region A, billing services, state provider associations, and individual provider organizations. Topics addressed at this meeting included:

- Role of the Ombudsmen and State Assignments
- New Supplier Manual
- DMERC Bulletins
- Seminar Frequently Asked Questions (FAQs)
- Updates from CMS
- PCOM Advisory Group Membership Criteria
- 2003 Seminar Recap
- Webex Online Seminars
- Data Analysis
- Current Educational Outreach
- Future Educational Opportunities and Plans
- Health Insurance Portability and Accountability Act (HIPAA)
- Physician Education
- DMEPOS Billing During an Inpatient Stay (Change Request (CR) 2613)

The second PCOM Advisory Group meeting was held on February 11, 2004, via teleconference. Members were notified via email of the details and registration process prior to the meeting. Minutes from this meeting are forthcoming.

Minutes from the 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 meeting minutes, this site contains supplementary information on the PCOM Advisory Group, a list of member organizations, and instructions on becoming a member. There are currently **membership openings** for fiscal year 2004, and **membership is free**. If you would like more information regarding the PCOM Advisory Group, or if you wish to become a member, please visit our Web site or contact the PET Department at 570-735-9666 and select Option 1.

## Online Education for Providers

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training Department is pleased to announce our newest learning option - Online Education - which will be available in three formats: live, archived, and tutorials. These Webcasting services are provided by WebEx.

Live online sessions are presented via the Internet and telephone. The audio portion is heard over the telephone, via conferencing, while the presentation is shown on your computer over the Internet. During live sessions, attendees can ask questions and interact, just as they would at a seminar attended in person. The use of this format will enable you to participate in the comfort of your own office, meeting room, or even your own home. Our live sessions will also be available through a library archive that can be accessed at any time for an encore presentation of the live sessions.

Tutorials are pre-recorded training sessions that can be viewed anytime, from anywhere, and most importantly, on your own schedule. All that is required is a computer with audio, which meets the system requirements. These sessions are a great learning tool to supplement either our live online or in-person seminars.

For more information regarding our online education, and to find out how you can participate, please visit the "Education - Articles and Publication Highlights" section of our Web site at ***www.umd.nycpic.com/dmeduc.html***.

# Web Site

## DMERC A ListServes

The Region A Durable Medical Equipment Regional Carrier (DMERC A) ListServes are used to notify subscribers **via email** of important and time-sensitive

Medicare program information, upcoming provider education and training events, and other important announcements or messages. Subscribers will also receive notice of the availability of the quarterly *DMERC Medicare News* on our Web site.

The ListServes are no-charge features on the DMERC A Web site. At present, there are two separate ListServes - a general one, which is used for the above notifications, and a Supplier Manual one, which is used for notifying subscribers of the availability of revised manual pages. To receive reminders and announcements via email, you can subscribe to the ListServes by visiting ***www.umd.nycpic.com/dmlistserve.html***.

To subscribe, type your email address in the appropriate "Subscribe" box, then click the "Submit" button. Subscribers can unsubscribe from the ListServes anytime. Just type your email address in the appropriate "Unsubscribe" box, and click the "Submit" button. This will delete you from that ListServe's email list.

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

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

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

### Program Safeguard Contractor ListServe

The Program Safeguard Contractor (PSC) for Region A, TriCenturion, LLC, recently established a ListServe. You can subscribe to this new ListServe by doing the following:

- Visit ***www.tricenturion.com/content/whatsnew_dyn.cfm***
- Click on the "TriCenturion's Listserv" link
- Follow the directions provided

## Region A Provider Information

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

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

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

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

## Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of

each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

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

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

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

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

## The Pulse of CMS

The Centers for Medicare & Medicaid Services (CMS) provided the Region A Durable Medical Equipment Regional Carrier (DMERC A) with a copy of the Winter 2003 edition of "The Pulse of CMS." This quarterly regional publication, for health care professionals, is available via the "Education - Articles and Publication Highlights" section of the DMERC A Web site at ***www.umd.nycpic.com/dmeduc.html***. (Note: This is a Portable Document Format (PDF) file, therefore, please follow the PDF download instructions listed on the Web page.)

## Announcing the New *Medlearn Matters…Information for Medicare Providers* Educational Resource for Medicare Providers

The following affects all Medicare providers.

### Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) and your Medicare Learning Network introduces *Medlearn Matters…Information for Medicare Providers*, a new educational resource for Medicare Providers. *Medlearn Matters…Information for Medicare Providers* is designed to inform you of important changes to the Medicare system in a user-friendly format that will accommodate your busy schedule.

Please let us know if these articles help you understand these changes more readily. Provide us with suggestions for improvements to articles. If there is a special topic of interest that you believe warrants an article, let us know and we will consider a special edition for that topic. To provide feedback, please go to: ***www.cms.hhs.gov/medlearn/suggestform.asp***

**Bookmark this page, use it frequently, and let us know how best to continue providing good service to you.**

### Background

CMS is committed to partnering with the Medicare physician, provider, and supplier communities so services to Medicare beneficiaries can be timely and of the highest quality. One way of providing the best services to Medicare patients is assuring that the providers of care have ready access to Medicare's latest coverage and reimbursement rules and policies in a brief, accurate, and easy-to-understand format.

CMS recognizes that the Medicare provider communities have been hampered by the number, frequency, and complexity of Medicare changes. CMS also appreciates the feedback from those same providers who indicate that Medicare rules and changes are not always relayed to them in an easy, timely, and consistent manner.

To address those issues, CMS has implemented a new initiative - "Consistency in Medicare Contractor Outreach Material" or CMCOM, designed to provide more timely information on Medicare changes. The product of this effort, *Medlearn Matters…Information for Medicare Providers*, is a series of articles prepared by actual clinicians and billing experts. *Medlearn Matters…Information for Medicare Providers* articles are tailored, in content and language, to the specific provider types who are affected by Medicare changes.

Previously, each Medicare carrier and intermediary was responsible for crafting educational articles within days of release of the related Medicare change. With this new effort, the Medicare carrier or fiscal intermediary will still be responsible for local provider education. However, they will benefit from the availability of *Medlearn Matters…Information for Medicare Providers* articles to support their efforts. These articles are easily accessible from the Medlearn Web site, which providers already access for other Medicare information.

Enlisting the expertise of medical professionals to develop these articles and providing them from a single location will result in more consistent, accurate, and timely information than in the past. This initiative supplements and should improve the ability of your carrier or intermediary to provide better service to you.

Those of you who have relied on Medicare Program Memorandums or Manual Transmittals on the Web, may be familiar with the Change Request (CR) documents and their accompanying CR numbers. Since you may have used the original CRs to get early information on upcoming changes, we think you will agree that those documents were not always clear as to provider impact and action needed.

One reason is that those CRs were written to provide instructions to Medicare carriers, intermediaries, and Medicare system maintainers. Thus, the focus of the message was quite different and probably contained more information than providers needed to know. The intent of *Medlearn Matters…Information for Medicare Providers* articles is to help focus the information more toward providers, to give you only the information you need and thus reduce the amount of time you need to spend on that information.

The articles will be placed on the Medlearn Web site on the new *Medlearn Matters…Information for Medicare Providers* page. Each article's number will usually correspond to the number of the Change Request (CR) that officially announced the change, but the number will be preceded by MM to show it is a related *Medlearn Matters…Information for Medicare Providers* article. There are exceptions, designated as Special Editions. These articles will be numbered in a distinctive manner, as "SEyynn" where "SE" stands for Special Edition, the "yy" is the two-digit year the article was released, and "nn" is the number of the special edition for that year. Thus, this first Special Edition article is numbered as SE0301.

To view all the articles available, please visit: ***www.cms.hhs.gov/medlearn/matters***

We hope you find this new vehicle of assistance to you and we invite your feedback.

**Disclaimer**
Medlearn Matters articles are prepared as a service to the public and are not intended to grant rights or impose obligations. Medlearn Matters articles may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

[Reference: Change Request (CR) 3129; Transmittal 54]

## Reminder to Providers/Suppliers: DMERC A Telephone Number for Beneficiaries

If providers/suppliers are servicing beneficiaries who have questions for the Region A Durable Medical Equipment Regional Carrier (DMERC A), please do **not** provide them with our supplier toll-free number. Rather, they should be given the DMERC A beneficiary toll-free number:

**800-842-2052**

(For PA beneficiaries only: 800-MEDICARE)

## Telephone Numbers

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

## Web Sites

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

## Addresses

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

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

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

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

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

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

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

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

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

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

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

# MEDICARE

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

***A CMS Contracted Carrier***