DMERC Medicare News

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Articles are identified by area of interest as follows: **DRU** = Drugs, **GEN** = General, **MOB** = Mobility/Support Surfaces, **O&P** = Orthotics & Prosthetics, **OXY** =Oxygen, **PEN** = Parenteral/Enteral Nutrition, **SPE** = Specialty Items, **VIS** = Vision

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/Finance

Current information on billing is available via the DMERC A Web site at: ***www.umd.nycpic.com/dmbilltips.html***

Elimination of Regulations for Written Statement of Intent

Medlearn Matters Number: 3310
Related Change Request (CR) #: 3310
Related CR Release Date: June 18, 2004
Related CR Transmittal #: 211
Effective Date: May 24, 2004
Implementation Date: July 19, 2004

The following information affects all Medicare providers.

Provider Action Needed

Impact to You - Effective with the claims filing period ending on December 31, 2004, and thereafter, Medicare will no longer accept Statements of Intent (SOIs) to extend the timely filing limit for filing initial claims.

What You Need to Know - Know the Medicare timely filing requirements for submitting claims. These requirements are in Chapter 1, Section 70 of the Medicare Claims Processing Manual, which may be found at:
www.cms.hhs.gov/manuals/104_claims/clm104index.asp

What You Need to Do - To ensure accurate claims processing, please submit filings in a timely manner and make certain that you will no longer utilize SOIs.

Background

Medicare regulations at 42 CFR Part 424.45 allowed for the submission of written SOIs to claim Medicare benefits. The purpose of an SOI was to extend the timely filing period for the submission of an initial claim. An SOI, by itself, did not constitute a claim, but rather was used as a placeholder for filing a timely and proper claim.

A Final Rule published in the Federal Register, dated April 23, 2004, Volume 69, Number 79, pages 21963-21966, amended 42 CFR Part 424 by removing the SOI provision at 424.45, effective May 24, 2004. Therefore, for the claims filing period ending on December 31, 2004, and all periods thereafter, Medicare carriers, intermediaries, and Medicare Regional Offices will no longer accept SOIs to extend the timely filing period for claims.

Additional Information

If you have questions regarding this issue, you may also contact your carrier or intermediary by their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll-free number for your carrier/intermediary may be found online at: ***www.cms.hhs.gov/providers/edi/anum.asp***

If you bill for Medicare Part B services, the toll-free number may be found online at:
www.cms.hhs.gov/providers/bnum.asp

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR 3310, at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR3310. Click on the link to open and view the file for the CR.

Individual Consideration (IC) Codes - Billing Reminder

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

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

Billing Reminder for A4927AX and A4928AX

Providers are reminded that when billing for end-stage renal disease (ESRD) dialysis supplies **A4927AX (Gloves, non-sterile, per 100)** and **A4928AX (Surgical mask, per 20)**, each code is to be billed to the DMERC as a quantity of one (1) for each 100 pair of gloves and a quantity of one (1) for each 20 surgical masks billed. These two items are no longer included as part of a kit.

Discontinued Codes for Wheelchair Cushions

This is a reminder that codes E0176, E0177, E0178, E0179, E0192, E0962, E0963, E0964, E0965, E1012, E1013, K0023, K0024, and K0114 were eliminated and are invalid for submission to Medicare on or after July 1, 2004. For more information, please refer to the article "Wheelchair Seating - New Policy" under the March 2004 Bulletins listed on the "What's New" page of the Region A Program Safeguard Contractor Web site at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

[Reference: Change Request (CR) 3289; Transmittal 179]

Billing Reminder for Wheelchair Options/Accessories

Providers are reminded that when billing for wheelchair options/accessories (as purchases), the right (RT) and left (LT) modifiers must be used when billing the same code for bilateral items (left and right) on the same date of service on the same claim line using the RT and LT modifiers and two units of service. When billing the same code for rental bilateral items on the same date of service, bill items on separate lines using the appropriate RT or LT modifier and one unit of service. Failure to bill using the RT and LT modifiers will result in a denial of services.

Advance Beneficiary Notice (ABN) Billing Reminder

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department would like to remind the supplier community that the Advance Beneficiary Notice (ABN) is applicable for same/similar equipment denials. The ABN can be obtained when the supplier is aware of a same or similar piece of equipment in the patient's history prior to the new item being furnished. In a situation where an ABN is properly obtained, suppliers must append the **GA** modifier to the appropriate procedure code. The DMERC A processing system is equipped to adjudicate these claims for the proper denial.

For further information on the proper use of the ABN, please view our ABN Web-based tutorial at: ***www.umd.nycpic.com/dme-eduonline.html***.

Skilled Nursing Facility Consolidated Billing L Codes – Durable Medical Equipment Regional Carrier and Fiscal Intermediaries

Medlearn Matters Number: MM3295
Related Change Request (CR) #: 3295
Related CR Release Date: May 28, 2004
Related CR Transmittal #: 191
Effective Date: June 28, 2004
Implementation Date: June 28, 2004

The following information affects Skilled Nursing Facilities (SNFs) and suppliers.

Provider Action Needed

Impact to You - As of April 1, 2004, suppliers cannot get paid for codes L5673 and L5679 for services provided to a beneficiary in a Part A SNF stay. These codes have replaced codes K0557 and K0558. Codes L5673 and L5679 were inadvertently left off the April 2004 quarterly update edits for SNF consolidated billing.

What You Need to Know - Once corrected, these codes will allow separate payment by Medicare Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FI) outside the perspective payment rate for Medicare beneficiaries in Part A SNF

stays. These codes will be added to the October quarterly update. When claims for L5679 and L5673 are rejected, the following incorrect messages will appear on your statement: *Remittance Advice American National Standards Institute (ANSI) Reason code 109, "Claims not covered by this payer/contractor. Claims must be sent to the correct payer/contractor;" and remark code MA101, "A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents."* Since these codes were mistakenly not added to the edits for services that are separately payable outside of consolidated billing and the PPS rate, the provider or supplier should not contact the SNF for payment on these claims.

What You Need to Do - If your claim for L5679 or L5673 services is not paid from April 1 through September 30, 2004, notify your DMERC or intermediary and request they re-open the claim and use the appropriate override code to process your claim for payment.

Background

Due to an inadvertent programming error, Medicare systems will not process payments for Healthcare Common Procedure Coding System (HCPCS) codes L5673 and L5679 as of April 1, 2004. These codes are described as follows:

- **L5673** - Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism, effective January 1, 2004.
- **L5679** - Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism, effective January 1, 2004.
- **L5673** and **L5679** replaced K0557 and K0558, which were terminated as of December 31, 2003. K0557 and K0558 are defined as follows:
  - K0557 - same definition as L5673, terminated December 31, 2003.
  - K0558 - Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557), terminated December 31, 2003.

Where appropriate, Medicare has instructed your DMERC or intermediary to pay interest for delayed payments.

Additional Information

If you have any questions regarding this issue, please contact your DMERC or intermediary at their toll free number. If you do not have that number, you may find it at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

To view the instruction issued to your carrier/intermediary regarding this issue, please visit: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. Scroll down the CR NUM column on the right and click on CR3295.

October 2004 Quarterly Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used For Skilled Nursing Facility (SNF) Consolidated Billing Enforcement

Medlearn Matters Number: MM3348
Related Change Request (CR) #: 3348
Related CR Release Date: July 9, 2004
Related CR Transmittal #: 224
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

The following information affects institutional providers billing claims to the Medicare Fiscal Intermediaries (FIs), and physicians, practitioners, and suppliers billing Medicare carriers for services.

Provider Action Needed

Impact to You - HCPCS codes are being added to or removed from the SNF consolidated billing enforcement list.

What You Need to Know - Services included on the SNF consolidated billing enforcement list will be paid to SNF Medicare providers only. Services excluded from the SNF consolidated billing enforcement list may be paid to Medicare providers other than SNFs. See *Background* and *Additional Information* sections for further explanation.

What You Need to Do - Be aware of the requirements explained below and how they can impact your Medicare payment.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the list of HCPCS codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (SNF PPS). Services appearing on this list submitted on claims to Medicare Fiscal Intermediaries (FIs) and Carriers, including Durable Medical Equipment Regional Carriers (DMERCs) will not be paid to any Medicare providers, other than a SNF, when included in SNF consolidated billing.

For non-therapy services, the SNF consolidated billing applies only when the services are furnished to a SNF resident during a covered Part A stay. However, the SNF consolidated billing applies to physical, occupational, or speech-language therapy services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services excluded from the SNF consolidated billing may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay.

Section 1888 of the Social Security Act codifies SNF PPS and consolidated billing. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates. New updates are required by changes to the coding system, not because the services subject to the SNF consolidated billing are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The codes below are listed as being added or removed from the annual update, mentioned above. Deletions from Major Category I F. below, specifically HCPCS code 36489, is being removed because the HCPCS was discontinued as of December 31, 2003. Additions to what is noted as Major Category III below means these services may be provided by any Medicare provider licensed to provide them, **except a SNF**, and are excluded from SNF PPS and consolidated billing. Additions to therapy inclusions, Major Category V below, mean SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries NOT in a Part A stay or in a SNF bed receiving ancillary services billed on TOB 22x.

Outpatient Surgery and Related Procedures *(Major Category I F., FI Annual Update, INCLUSION)*

Remove 36489◆ – placement of cv catheter

Note on Code above:

Code discontinued effective December 31, 2003.

Customized Prosthetic Devices *(Major Category III, FI Annual Update, EXCLUSION)*

For FI claims processing, remove K0556*, K0557*, K0558*, K0559* - Addition to lower extremity, below knee/above knee, custom fab. **For carrier claims processing**, these codes will remain payable for dates of service prior to January 1, 2004.

Add L5673**** - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism

Add L5679**** - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

Chemotherapy Administration *(Major Category III, FI Annual Update, EXCLUSION)*

Remove 36489***** - placement of cv catheter

Notes on Codes above:

* Codes were replaced by L5673, L5679, L5681 and L5683.

** Codes are added to exclusion list retroactive to 1/1/04.

*** Code discontinued effective 12/31/03.

Therapies *(Major Category V, FI Annual Update, for FI billing use revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology)*

Remove G0295^ Electromagnetic stimulation, to one or more areas (Not covered by Medicare) (This code was not previously included on carrier coding files.)

Remove G0237^^ - Therapeutic procd strg endur

Remove G0238^^ - Oth resp proc, indiv

Remove G0239^^ - Oth resp proc, group

Remove G0302^^ - pre-op LVRS service

Remove G0303^^ - pre-op service LVRS 10-15dos

Remove G0304^^ - pre-op service LVRS 1-9dos

Remove G0305^^ - post-op service LVRS min 6dos

Add G0329 ^^^– electromagnetic therapy, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

Notes on Codes above:

^ This code was erroneously added to file. Code was not previously included on carrier coding files.

^^ These codes are not considered therapy codes and are not payable to a SNF. They were inadvertently added to the table.

^^^ This code was added to the therapy inclusion list effective July 1, 2004. (Information concerning this code was not received in time to issue a July 2004 update.)

Additional Information

Each January, separate instructions are published for FIs, Carriers and DMERCs for the annual notice on the SNF consolidated billing. The 2004 Annual Updates for FIs can be found on the CMS Web site at: ***www.cms.hhs.gov/manuals/pm_trans/R19CP.pdf***. This instruction is referred to as CR2926.

Overall information regarding SNF CB can be found at: ***www.cms.hhs.gov/medlearn/snfcode.asp***

Quarterly updates now apply to FIs, Carriers and DMERCs. There has been one joint FI/Carrier/DMERC quarterly update published subsequent to the 2004 Annual Updates. This update can be found at: ***www.cms.hhs.gov/manuals/pm_trans/R92CP.pdf*** That instruction is also known as CR3070.

The official instruction issued to your carrier regarding this change may be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. From that web page, look for CR3348 in the CR NUM column on the right, and then click on the file for that CR.

Skilled Nursing Facility Consolidated Billing: Services Furnished Under an "Arrangement" with an Outside Entity

Medlearn Matters Number: MM3248
Related Change Request (CR) #: 3248
Related CR Release Date: May 21, 2004
Related CR Transmittal #: 183
Effective Date: April 1, 2004
Implementation Date: July 1, 2004

The following information affects Skilled Nursing Facilities (SNF), physicians, non-physician practitioners, suppliers, and providers.

Provider Action Needed

Impact to You - Affected providers should note that this instruction is being issued as a reminder of the applicable consolidated billing requirements that pertain to Skilled Nursing Facilities (SNF) and to the outside suppliers that serve SNF residents.

What You Need to Know - Whenever a SNF resident receives a service that is subject to SNF consolidated billing from an outside supplier, the Social Security Act requires the SNF and the supplier to enter into an "arrangement." Under an "arrangement," Medicare's payment to the SNF represents payment in full for arranged-for services and suppliers must look to the SNF (rather than to Medicare Part B) for their payment.

What You Need to Do - Be aware of the requirements explained below and how they can impact your Medicare payments.

Background

The SNF consolidated billing provisions of the Social Security Act[1] place the Medicare billing responsibility for most of the SNF's residents' services with the SNF itself.

In addition, Part A consolidated billing requires that an SNF must include on its Part A bill:

- Almost all of the services that a resident receives during the course of a **Medicare-covered stay**;
- Except for those services that are specifically **excluded**

from the SNF's global prospective payment system (PPS) per diem payment for the covered stay. (These "excluded" services remain separately billable to Part B directly by the outside entity that actually furnishes them.)

Also, Part B consolidated billing makes the SNF itself responsible for submitting the Part B bills for any **physical, occupational, or speech-language therapy services** that a resident receives during a **noncovered** stay.

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either:

- Furnish the service directly with its own resources, **or**
- Obtain the service from an outside entity (such as a supplier) under an "arrangement," as described in the Social Security Act.[2]

This "arrangement" must constitute a written agreement to reimburse the outside entity for Medicare-covered services subject to consolidated billing, i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

Problematic Situations

There are various **problematic situations** in which an SNF resident receives a service from an outside supplier (or practitioner) that is subject to consolidated billing, in the absence of a valid arrangement between that entity and the SNF.

In some instances, the supplier may have been unaware that the beneficiary was in a Part A stay until its separate Part B claim was denied. In the absence of a written agreement, the supplier may have difficulty in obtaining payment from the SNF, even though the service at issue is a type of service that is Medicare-covered and included in the SNF's global PPS per diem.

As discussed in greater detail below, such situations most commonly arise in one of the following scenarios:

- A SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier; or
- A supplier fails to ascertain a beneficiary's status as an SNF resident when the beneficiary (or another individual acting on the beneficiary's behalf) seeks to obtain such services directly from the supplier without the SNF's knowledge.

Whenever a supplier furnishes services that are subject to consolidated billing in the absence of a written agreement with the SNF, the supplier risks not being paid for the services. In addition, the supplier in this situation might improperly attempt to bill Part B directly for the services. The inappropriate submission of a Part B bill for such services could result not only in Medicare's noncoverage of the services themselves, but also in the imposition of civil money penalties, as explained below.

Along with all of the other potentially adverse consequences of such practices, the SNF risks violating the terms of the Medicare provider agreement (which requires a SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself).

In order to help prevent these types of problems from arising, **this instruction is being issued as a reminder of the applicable consolidated billing requirements that pertain to SNFs and to the outside suppliers that serve SNF residents**.

Billing Arrangements

Under an arrangement as defined in the Social Security Act[3]:

- Medicare's payment to the SNF represents payment in full for arranged-for services; and
- Suppliers must look to the SNF (rather than to Part B) for their payment.

Further, in entering into such arrangements, the SNF cannot function as a mere billing conduit, and must exercise professional responsibility and control over the arranged-for service.[4] The long-term care (LTC) facility requirements for program participation further provide that under such an arrangement, the SNF must **specify in writing** that it assumes responsibility for the quality and timeliness of the arranged-for service.[5]

Medicare does not prescribe the actual terms of the SNF's written agreement with its supplier (such as the specific amount or timing of the supplier's payment by the SNF). These are arrived at through direct

negotiation between the parties to the agreement. However, in order for a valid "arrangement" to exist for those services that are subject to consolidated billing, **the SNF must have a written agreement in place with its supplier**, which specifies how the supplier is to be paid for its services. The existence of such an agreement also provides both parties with a means of resolution in the event that a dispute arises over a particular service.

If an SNF elects to obtain services that are subject to consolidated billing from an outside supplier, but fails to execute a written agreement with that supplier, then there is no valid arrangement for the services as contemplated under the Social Security Act.[6]

Not only would this potentially result in Medicare's noncoverage of the particular services at issue, but the SNF would also risk being found in violation of the terms of its provider agreement. Under the Social Security Act, the SNF's provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision.[7]

Further, the Social Security Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.[8]

Accordingly, whenever an SNF elects to utilize an outside supplier to furnish a service that is subject to consolidated billing, the SNF must have a written agreement in place with that supplier. Conversely, whenever an outside supplier furnishes such a service to an SNF resident, it must do so under a written agreement with the SNF.

Problems with Arrangements

Problems involving the absence of a valid arrangement between an SNF and its supplier typically tend to arise in one of the following two situations:

- **The first problem scenario** occurs when an SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay.

  This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing. Based on the inaccurate impression that the resident's SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service, and only learns of the actual status of the resident's Medicare-covered SNF stay when that Part B claim is denied. In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

  While it is recognized that inadvertent errors may occasionally occur in the course of furnishing such information, an SNF should not only make a good faith effort to furnish accurate information to its supplier, but should have a written agreement in place that provides for direct reimbursement of the supplier once such an error is called to its attention.

  By contrast, in the scenario at issue, the SNF refuses to pay the supplier for the service even **after** being apprised of the inaccuracy of its initial information. As discussed previously, having a valid arrangement in place for the disputed service would not only ensure compliance with the consolidated billing requirements, but also would provide a vehicle for resolving the dispute itself.

- **The second problem scenario** involves a resident who temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF.

  As in the previous scenario, this results in the services being furnished to the resident by an outside entity in the absence of a valid arrangement with the SNF. In addition, such a practice impedes the SNF from meeting its responsibility to provide comprehensive oversight of the resident's care and treatment.

SNFs can act to prevent such problems from arising by ensuring that each resident (and, if applicable, his or her representative) is fully aware of the applicable requirements.

For example, the Medicare law[9] guarantees a beneficiary's free choice of any qualified entity that is willing to furnish services to the beneficiary. However, in selecting a particular SNF, the beneficiary has

effectively exercised this right of free choice with respect to the **entire package** of services for which the SNF is responsible under the consolidated billing requirement, including the use of any outside suppliers from which the SNF chooses to obtain such services.

In addition, the Long Term Care (LTC) facility participation requirements[10] direct the SNF to advise each resident, on or before admission and periodically during the stay, of any charges for services not covered by Medicare.

In providing such advice periodically throughout each resident's stay, the SNF should take particular care to include any resident who is about to leave the facility temporarily, in order to ensure that the resident (and, if applicable, the resident's representative) understands the need to consult the SNF before obtaining any services offsite.

Moreover, while the SNF itself should take reasonable steps to prevent such problems from arising, the supplier is also responsible for being aware of and complying with the consolidated billing requirements.

This means that prior to furnishing services to a Medicare beneficiary, **the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier's services**. If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing services to that beneficiary.

Implementation

The implementation date for this instruction is July 1, 2004.

Additional Information

The *Medicare Claims Processing Manual, Pub 100-04, Chapter 6 (SNF Inpatient Part A Billing), Section 10.3 (Types of Services Subject to the Consolidated Billing Requirement for SNFs)* has been revised. The following new sections have also been added:

- Section 10.4 (Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" with an Outside Entity);
- Subsection 10.4.1 (Written Agreement); and
- Subsection 10.4.2 (SNF and Supplier Responsibilities).

These revised/new portions of the manual are attached to the official instruction issued to your carrier regarding this change. That instruction (CR3248) may be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. From that Web page, look for CR3248 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

The *Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-1, Chapter 5 (Definitions), Section 10.3 (Under Arrangements)* can be found at the following CMS Online Manuals Web site: ***www.cms.hhs.gov/manuals/cmsindex.asp***

[1] Social Security Act, Sections 1862(a)(18), 1866(a)(1)(H)(ii), and 1888(e)(2)(A).

[2] Social Security Act, Section 1861(w).

[3] Social Security Act, Section 1861(w).

[4] Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-1, Chapter 5 (Definitions), Section 10.3 (Under Arrangements).

[5] Code of Federal Regulations, 42 CFR 483.75(h)(2).

[6] Social Security Act, Section 1862(a)(18).

[7] Social Security Act, Section 1866(a)(1)(H)(ii), and the Code of Federal Regulations, 42 CFR 489.20(s).

[8] Social Security Act, Section 1866(g).

[9] Social Security Act, Section 1802.

[10] Code of Federal Regulations, 42 CFR 483.10(b)(6).

Unsolicited/Voluntary Refunds

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue appropriate criminal, civil, or administrative remedies arising from or relating to these or other claims.

[Reference: Change Request (CR) 3274; Transmittal 42]

Payment to Bank

Effective July 25, 2004, this instruction revises the criteria for payment to be sent to a bank in the name of a provider/physician/supplier. Medicare payments due a provider or supplier of services may be sent to a bank (or similar financial institution) for deposit in the provider/supplier's account so long as the following requirements are met:

- The bank may provide financing to the provider/supplier, as long as the bank states in writing, in the loan agreement, that it waives its right of offset. Therefore, the bank may have a lending relationship with the provider/supplier and may also be the depository for Medicare receivables; and
- The bank account is in the provider/supplier's name and only the provider/supplier may issue instructions on that account. The bank shall be bound by only the provider/supplier's instructions. No other agreement that the provider/supplier has with a third party shall have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier's account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier's agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.

For more information, refer to Section 30.2.5 of Chapter 1 in Pub. 100-4, Medicare Claims Processing Manual (***www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf***). Also, see the Medlearn Matters article on the Centers for Medicare & Medicaid Services Web site (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3079.pdf***).

[Reference: Change Request (CR) 3079; Transmittal 213]

Chapter 5 – Financial Management Manual: Section 420 – Procedures for Re-issuance and Stale Dating of Medicare Checks

Medlearn Matters Number: MM2951
Related Change Request (CR) #: 2951
Related CR Release Date: July 16, 2004
Related CR Transmittal #: 49
Effective Date: August 16, 2004
Implementation Date: August 16, 2004

The following information affects physicians, suppliers, and providers.

Provider Action Needed

Impact to You - The Centers for Medicare & Medicaid Services (CMS) is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

What You Need to Know - This instruction updates the Medicare Financial Management Manual (Pub. 100-06) and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding CMS procedures for re-issuance and stale dating of Medicare checks.

What You Need to Do - Be aware of these instructions in the event you have a problem in the future regarding lost, stolen, defaced, mutilated, destroyed, forged, or uncashed checks from your Medicare carrier/intermediary.

Background

This instruction updates the *Medicare Financial Management Manual (Pub. 100-06)* and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding the CMS procedures for re-issuance and stale dating of Medicare checks, which expired in September 2002. Legal authority for the CMS re-issuance and stale dated check policy is contained in Medicare regulations published at 42 CFR 424.352.

Introduction - As part of the CMS effort to improve financial reporting, CMS is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

Re-issuing Medicare Checks - In December 1993, CMS

issued *42 Code of Federal Regulations (CFR) Subpart M – Replacement and Reclamation of Medicare Payments 424.352: Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements*. All Medicare contractors must re-issue checks in accordance with 42 CFR 424.352.

The provisions of this regulation require that a Medicare contractor (fiscal intermediary or carrier) perform certain tasks upon notification by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. These tasks are as follows:

A. The Medicare contractor must contact the financial institution on which the check was drawn to determine whether the check has been negotiated.

B. If the check **has** been negotiated:
   1. The Medicare contractor will provide the payee with a copy of the check and other pertinent information (such as a claim form, affidavit, or questionnaire to be completed by the payee) required to pursue the claim in accordance with State law and commercial banking regulations.
   2. To pursue the claim, the payee must examine the check and certify (by completing the claim form, affidavit, or questionnaire) that the endorsement is not the payee's.
   3. The claim form and other pertinent information are sent to the Medicare contractor for review and processing of the claim.
   4. The Medicare contractor reviews the payee's claim. If the Medicare contractor determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The Medicare contractor takes further action to recover the proceeds of the check in accordance with State law and regulations.
   5. Once the Medicare contractor recovers the proceeds of the initial check, the Medicare contractor issues a replacement check to the payee.
   6. If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own, and the Medicare contractor will not re-issue the check to the payee.

C. If the check has not been negotiated:
   1. The Medicare contractor arranges with the bank to stop payment on the check; and
   2. Except as provided in paragraph (D) of 42 CFR 424.352, the Medicare contractor re-issues the check to the payee.

D. No check may be reissued under (C)(2) unless the claim for a replacement check is received by the contractor no later than one year from the date of issuance of the original check, unless State law (including any applicable Federal banking laws or regulations that may affect the relevant State proceeding) provides a longer period, in which case that State law will apply.

Medicare contractors may receive requests for re-issuance of Medicare checks that are older than one year. Based on 42 CFR 424.352 (summarized above), Medicare contractors should inform beneficiaries and providers/ physicians/ suppliers regarding the possibility that State law may provide a more favorable time frame for re-issuance. Requests for re-issuance based on State law should be forwarded by Medicare contractors to their Regional Office. The Regional Office will work with the Regional Office General Counsel to resolve these requests on a case-by-case basis.

Medicare contractors regularly receive requests for re-issuance of Medicare checks that are older than one year. Under 42 CFR 424.352 many of these requests must be denied. However, 42 CFR 424.352 applies **only** to checks that have been lost, stolen, defaced, mutilated, destroyed, or paid on a forged endorsement. Accordingly, Medicare checks that are in the physical possession of the payee, have not been defaced or mutilated, and have not been negotiated are not subject to the one-year time limit for re-issuance required by 42 CFR 424.352 (d). Therefore, if the below criteria below are met, such checks may be re-issued by the Medicare contractor even if they are older than one year. The criteria are:

1. The payee (beneficiary, physician, supplier, provider, etc.) and/or authorized representative can present the physical check;
2. The Medicare contractor can confirm that the check was not previously reissued; and
3. Re-issuance is not barred by a Federal and/or State statute of limitations.

Any questions that the Medicare contractors have regarding application of the above criteria should be forwarded to their Regional Office. The Regional Office will work with the Regional Office General Counsel to resolve the questions.

Stale Dating of Checks - Medicare contractors are expected to continuously review all outstanding checks, take the appropriate action to stale date checks in conformance with Federal and/or State/local banking regulations, and adjust financial reporting for these actions. Medicare contractors must advise their financial institution of the change in the status of a check.

Outstanding checks are checks that have been issued as payment for Medicare benefits and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Checks are "voided" by rendering them non-negotiable either physically or by placing a stop payment on them.

Stale dated checks are checks that have reached a specific age from date of issue (e.g., one year from the date of issuance) and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Additionally, once a check has been stale dated and is no longer negotiable, the financial institution must be notified in writing.

Undeliverable Checks - Medicare providers, physicians, suppliers, and beneficiaries are responsible for providing their Medicare contractor with their current and accurate mailing address.

The Medicare contractors must comply with the policy established by the "Do Not Forward (DNF) Initiative." This policy requires Medicare contractors to re-issue the check based on the receipt of updated verified address information per Form CMS-855; and if no updated address information has been submitted, then Medicare contractors must void any returned checks. Checks voided due to DNF may be re-issued in accordance with the instructions in the preceding section titled "Re-issuing Medicare Checks."

Implementation

The implementation date for this instruction is August 16, 2004.

Related Instructions

The *Medicare Financial Management Manual, Pub. 100-06, Chapter 5 (Financial Reporting/ Section 420-Procedures for Re-issuance and Stale Dating of Medicare Checks)* is new. These updated manual instructions will be incorporated into the new Internet-only Office of Financial Management Manual, but are available now as part of the official instruction issued to your carrier/intermediary. This instruction (CR2951) can be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. From that web page, look for CR2951 in the CR NUM column on the right, and click on the file for that CR.

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

July Quarterly Update for 2004 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

Medlearn Matters Number: MM3253
Related Change Request (CR) #: 3253
Related CR Release Date: May 7, 2004
Related CR Transmittal #: 171
Effective Date: January 1, 2004 for revised 2004 fee schedule amounts and April 1, 2004 for fee schedule amounts for codes K0630 through K0649
Implementation Date: July 6, 2004

The following information affects physicians, suppliers, and providers.

Provider Action Needed

Impact to You - This instruction provides details regarding the July 2004 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedules.

What You Need to Know - The 2004 fee schedule amounts for selected Healthcare Common Procedure Coding System (HCPCS) codes are being revised to correct calculation errors.

What You Need to Do - Refer to the *Background* and *Additional Information* sections of this instruction for further details regarding these changes.

Background

The 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.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Section 1834(a), (h), and (i)), and payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

This instruction provides specific details regarding the July quarterly update for the 2004 DMEPOS fee schedule.

Codes **K0630 through K0649** were added to the HCPCS effective April 1, 2004. The fee schedule amounts for these codes were not computed in time to be implemented as part of the April quarterly update and will be implemented as part of the July quarterly update. The Durable Medical Equipment Regional Carriers (DMERCs) have calculated local fee schedule amounts for purposes of paying claims for codes K0630 through K0649 received prior to July 1, 2004.

Codes **K0650 through K0669** are being added to the HCPCS effective July 1, 2004. The fee schedule amounts for these codes will not be computed in time to be implemented as part of the July quarterly update because the products that fall under these codes have not yet been identified. DMERCs and Regional Home Health Intermediaries (RHHIs) will determine the payment amounts for K0650 through K0669 when such claims are received for services on or after July 1, 2004, through September 30, 2004. The fee schedule amounts for codes K0650 through K0669 will be implemented as part of the October quarterly update.

Codes **A4216, A4217, A4217AU, L5782, and L8511 through L8514** have been paid on an individual consideration basis by the DMERCs and Fiscal Intermediaries (FIs). Fee schedule amounts are being established for these codes as part of the July quarterly update. For service in 2004, FIs will use the fee schedule amount for A4217 without the AU modifier.

Code **A4290** was added to the fee schedule under the prosthetic device category. It does not qualify, however, for separate payment under the prosthetic device benefit. This code is being removed from the DMEPOS fee schedule file as part of the July quarterly update.

Also, please note that codes **E0973, E0990, E1225, and E1226** have been added to the list of codes requiring a Certificate of Medical Necessity, while code E0300 has been removed from that list.

Implementation

The implementation date for this instruction is July 6, 2004.

Related Instructions

The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule)*, which can be reviewed at the following Centers for Medicare & Medicaid Services (CMS) Web site:
www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR3253 in the CR NUM column on the right, and click on the file for that CR.

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

In addition, a comprehensive overview of the HCPCS can be found at the following CMS Web site:
www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp

Fee Schedule Updates

The 2004 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Region

A Durable Medical Equipment Regional Carrier Web site, ***www.umd.nycpic.com/dmfees.html***. In addition to the second quarter update for oral anticancer drug fees, the following notices can be accessed via the "2004 Fee Schedule Article/Information" link. (*Note*: Also, see the article "Individual Consideration (IC) Codes - Billing Reminder" on page 2.)

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

July 2004 Quarterly Fee Updates

The following procedure codes have been added to the fee schedule, effective for dates of service on or after January 1, 2004: A4216, A4217, A4217AU, L5782, L8511, L8512, L8513, and Healthcare Common Procedure Coding System (HCPCS) codes K0630-K0649 have been added to the fee schedule with the effective date of service on or after April 1, 2004. HCPCS codes K0631, K0633, K0638, K0641, K0643, K0644, and K0645 will be IC (Individual consideration).

HCPCS	A4216	A4217	A4217
MOD			AU
Ceiling	0.45	3.13	3.13
Floor	0.38	2.66	2.66
CT	0.45	3.13	3.13
DE	0.45	3.13	3.13
MA	0.45	2.66	2.66
ME	0.45	2.66	2.66
NH	0.45	2.66	2.66
NJ	0.45	3.13	3.13
NY	0.41	2.66	2.66
PA	0.45	3.13	3.13
RI	0.40	2.66	2.66
VT	0.45	3.05	3.05

HCPCS	K0630	K0632	K0634
MOD			
Ceiling	33.05	69.83	67.83
Floor	24.79	52.38	50.87
CT	27.08	57.23	55.58
DE	27.08	57.23	55.58
MA	27.08	57.23	55.58
ME	27.08	57.23	55.58
NH	27.08	57.23	55.58
NJ	27.08	57.23	55.58
NY	27.08	57.23	55.58
PA	27.08	57.23	55.58
RI	27.08	57.23	55.58
VT	27.08	57.23	55.58

HCPCS	K0635	K0636	K0637
MOD			
Ceiling	80.64	433.87	76.39
Floor	60.48	325.40	57.29
CT	66.09	355.52	62.60
DE	66.09	355.52	62.60
MA	66.09	355.52	62.60
ME	66.09	355.52	62.60
NH	66.09	355.52	62.60
NJ	66.09	355.52	62.60
NY	66.09	355.52	62.60
PA	66.09	355.52	62.60
RI	66.09	355.52	62.60
VT	66.09	355.52	62.60

HCPCS	K0639	K0640	K0642
MOD			
Ceiling	167.91	850.20	265.87
Floor	125.93	637.65	199.40
CT	137.60	696.67	217.86
DE	137.60	696.67	217.86
MA	137.60	696.67	217.86
ME	137.60	696.67	217.86
NH	137.60	696.67	217.86
NJ	137.60	696.67	217.86
NY	137.60	696.67	217.86
PA	137.60	696.67	217.86
RI	137.60	696.67	217.86
VT	137.60	696.67	217.86

HCPCS	K0646	K0647	K0648
MOD			
Ceiling	512.41	1,264.72	768.85
Floor	384.31	948.54	576.64
CT	419.89	1,036.35	630.01
DE	419.89	1,036.35	630.01
MA	419.89	1,036.35	630.01
ME	419.89	1,036.35	630.01
NH	419.89	1,036.35	630.01
NJ	419.89	1,036.35	630.01
NY	419.89	1,036.35	630.01
PA	419.89	1,036.35	630.01
RI	419.89	1,036.35	630.01
VT	419.89	1,036.35	630.01

HCPCS	K0649	L5782	L8511
MOD			
Ceiling	1,003.39	4,052.69	69.88
Floor	752.54	3,039.52	52.41
CT	822.21	3,320.90	57.26
DE	822.21	3,320.90	57.26
MA	822.21	3,320.90	57.26
ME	822.21	3,320.90	57.26
NH	822.21	3,320.90	57.26
NJ	822.21	3,320.90	57.26
NY	822.21	3,320.90	57.26
PA	822.21	3,320.90	57.26
RI	822.21	3,320.90	57.26
VT	822.21	3,320.90	57.26

HCPCS MOD	L8512	L8513	L8514
Ceiling	2.09	4.99	90.61
Floor	1.56	3.74	67.96
CT	1.70	4.08	74.24
DE	1.70	4.08	74.24
MA	1.70	4.08	74.24
ME	1.70	4.08	74.24
NH	1.70	4.08	74.24
NJ	1.70	4.08	74.24
NY	1.70	4.08	74.24
PA	1.70	4.08	74.24
RI	1.70	4.08	74.24
VT	1.70	4.08	74.24

Wheelchair Cushion Fees

The fees for wheelchair cushion codes K0650-K0669 have not been established. Refer to the Region A Program Safeguard Contractor (TriCenturion) March 2004 Bulletin article "Wheelchair Seating - New Policy":

"the only products which may be billed using codes K0650-K0657 and K0662-K0665 and the only brand name products that may be billed using codes K0658 or K0666 are those products for which a written coding verification has been made by the Statistical Analysis DME Regional Carrier (SADMERC). Information concerning the documentation that must be submitted to the SADMERC for a Coding Verification Request can be found on the SADMERC web site or by contacting the SADMERC."

Although pricing information is not required on the SADMERC application for Coding Verification Request, it should be submitted along with the request. The wholesale and suggested retail pricing information submitted with the Coding Verification Request will be used to determine the gap-fill fee until the fee schedule is established.

Wheelchair Cushions - Required Added Documentation

The fees for wheelchair cushion codes K0650-K0669 have not been established for July 2004. These codes will be priced as IC (individual consideration) until October 2004, when fees are established. Suppliers are reminded to submit documentation that includes manufacturer information, containing make and model number. If this information is not submitted with the claim, it will result in a denial.

[References: Change Request (CR) 3069, Transmittal 83; CR 3153, Transmittal 131; CR 3289, Transmittal 179]

Clarification of Change Request 2631

Medlearn Matters Number: SE0429
Related Change Request (CR) #: N/A
Implementation Date: N/A

The following information affects all physicians, non-physician practitioners, and suppliers billing for services paid under the Medicare physician fee schedule and for anesthesia services.

Provider Action Needed

On August 1, 2003, the Centers for Medicare & Medicaid Services (CMS) released Change Request (CR) 2631 to enforce the carrier jurisdiction rules effective for claims received on or after April 1, 2004. The CR has resulted in some confusion and has generated a number of calls to carrier call centers. This article provides some further clarification and, hopefully, will eliminate the confusion.

Background

Medicare carriers process Part B fee-for-service claims for covered services furnished in specific geographic areas (e.g., Florida). Services paid under the Medicare Physician Fee Schedule (MPFS) and anesthesia services are paid by the Medicare carrier with jurisdiction over the geographical area where the services are furnished. Jurisdiction is based on the zip code of the area where the service was rendered.

Physicians, suppliers, and group practices that provide physician fee schedule services at more than one office/practice location may submit their claims through one office to the carrier for processing. However, ***the specific location where the services are provided*** must be entered on the claim so that the correct jurisdiction and correct MPFS amount can be applied to the claim.

Effective for claims received on or after April 1, 2004, this applies to all **places of service (POS)** except "home." For POS "home," the Medicare carriers will use the beneficiary address on file to determine geographical payment.

Electronic Claims - As reflected in the implementation guide of the 4010A1 version of the ASC X12N 837 electronic claims format, 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, the pay-to provider, or claim level service facility location.

Refer to the current implementation guide of the ASC X12N 837 to determine how information must be entered on a claim. **The following information is based on the implementation guide:**

- On version 4010A1 of the ASC X12N 837 electronic claim format, the Billing Provider loop 2010AA is required and must always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, ***only*** the Billing Provider must be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider must be entered.
- If the Pay-To Provider Name and Address loop 2010AB is ***not*** the same as the Billing Provider, ***both*** must be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) must be entered.
- 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.

Paper Claims Submitted on the Form CMS-1500 - It is acceptable for claims to contain POS "home" and an additional POS code. No service address for POS "home" needs to be entered in Item 32 in this situation because the address will be drawn from the beneficiary file and the information on the claim will apply to the other POS.

The specific name, address, and zip code of the location where the services were furnished must be entered on the claim in Item 32. **This applies even if the place of service is "office."** The zip code of the address entered in Item 32 will be used to price the claim.

For carriers to be able to correctly determine where services were provided and pay correct locality rates, no more than one name, address, and zip code may be entered in Item 32 of the Form CMS-1500. Assigned claims with more than one address entered in Item 32 will be rejected and unassigned claims will be denied.

If POS "home" and more than one additional POS code is entered, assigned claims will be rejected and unassigned claims will be denied.

Physicians, non-physician practitioners, and suppliers that have had claims rejected or denied must resubmit the claims with the correct information entered in Item 32 in order to have the claims considered for payment.

Additional Information

To view CR2631, go to:
www.cms.hhs.gov/manuals/pm_trans/R169CP.pdf

Important Reminder: Elimination of the 90-day Grace Periods for ICD-9-CM and HCPCS Codes

Effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. **Claims containing a discontinued ICD-9-CM diagnosis code will be returned as unprocessable.** For more information, refer to the Medlearn Matters article on CMS' Web site (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3094.pdf***).

Effective January 1, 2005, CMS will no longer provide a 90-day grace period for providers to use in billing discontinued HCPCS codes. The elimination of the grace period applies to the annual HCPCS update and to any mid-year coding changes. **Claims containing discontinued HCPCS codes will be rejected.** For more information, refer to the Medlearn Matters article (***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3093.pdf***).

Elimination of the ICD-9-CM and HCPCS grace periods is a Health Insurance Portability and Accountability Act (HIPAA) compliancy issue.

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Medlearn Matters Number: MM3303
Related Change Request (CR) #: 3303
Related CR Release Date: June 18, 2004
Related CR Transmittal #: 210
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

The following information affects physicians, suppliers, and providers.

Provider Action Needed

Impact to You - Medicare will soon issue the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2004.

What You Need to Know - Remember that, as of October 1, 2004, Medicare no longer can provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.

What You Need to Do - Be ready to use the updated codes on October 1, 2004. Refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

Background

This instruction is a reminder that Medicare carriers and intermediaries will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2004; and
- Discharges on or after October 1, 2004, for institutional providers.

The Centers for Medicare & Medicaid Services (CMS) has been evolving the use of ICD-9-CM codes as follows:

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS-1450.
- On April 1, 1989, the use of ICD-9-CM codes became mandatory for all physician services submitted on Form CMS-1500.
- Effective October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59) (see Change Request (CR) 2725, dated June 6, 2003, at ***www.cms.hhs.gov/manuals/pm_trans/B03045.pdf***).
- Effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094 dated February 6, 2004, at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3094.pdf***).

Updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment System and are effective each October first. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004.

After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Web site: ***www.cms.hhs.gov/medlearn/icd9code.asp***. The update should be available at this site in June.

Implementation

The implementation date for this instruction is October 4, 2004.

Related Instructions

The *Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service)* has been revised. The updated manual instructions are included in the official instruction issued to your carrier, and it can be found

by going to:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that Web site, look for CR3303 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Additional Information

The new, revised, and discontinued ICD-9-CM diagnosis codes are posted annually on the following CMS Web site: ***www.cms.hhs.gov/medlearn/icd9code.asp***

Providers can view the new updated codes at this Web site in June and providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

In addition, the National Center for Health Statistics (NCHS) also will place the new ICD-9-CM Addendum on their Web site (***www.cdc.gov/nchs/icd9.htm***) in June, which is also available for providers to visit.

EDI & HIPAA

Current information on HIPAA is available via the DMERC A Web site at: ***www.umd.nycpic.com/emc&hipaa.html***

Attention Electronic Billers - Updated Coversheet for Additional Documentation

The Region A Durable Medical Equipment Regional Carrier (DMERC A) posted an updated coversheet, for use when faxing or mailing additional documentation to our office for your electronically transmitted claims, on our Web site at: ***www.umd.nycpic.com/extra.html***. Please begin using this updated form as soon as possible.

When submitting additional documentation for claims, the documentation must be received in our office at least 48 hours (two business days) before the claim is transmitted. This is particularly important when transmitting after 5:00 p.m., over the weekend, or on holidays. (***Reminder***: Certificates of Medical Necessity (CMNs) are **not** considered additional documentation.)

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Medlearn Matters Number: MM3227
Related Change Request (CR) #: 3227
Related CR Release Date: April 30, 2004
Related CR Transmittal #: 154
Effective Date: July 1, 2004
Implementation Date: July 6, 2004

The following information affects all providers.

Provider Action Needed

Be aware of the current remittance advice remark and reason codes to understand actions taken on your claims.

Background

The Centers for Medicare & Medicaid Services (CMS) maintains the remittance advice remark code list, one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG).

The complete list of these codes may be found at: ***www.wpc-edi.com/codes/Codes.asp***. The list is updated three times per year.

By July 6, 2004, all Medicare carriers and fiscal intermediaries (FIs), including the durable medical equipment carriers (DMERCs) and the Regional Home Health Intermediaries (RHHIs), will have incorporated all current remark code changes in their Medicare systems.

Remark Codes Changes - The following table summarizes remark code changes made from November 1, 2003 to February 29, 2004.

New Codes:

N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.
N214	Missing/incomplete/invalid history or history of the related initial surgical procedure(s).
N215	A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own determination.
N216	Patient is not enrolled in this portion of our benefit package.

Modified Remark Codes (Effective 4/1/04):

M119 Missing/incomplete/invalid/deactivated/withdrawn National Drug Code.

N115 This decision is based on a Local Medical Review Policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at ***http://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/LCD.

Modified Remark Codes (Effective 2/1/04):

M51 Missing/incomplete/invalid procedure code(s) and/or dates.

M69 Paid at the regular rate because you did not submit documentation to justify the modified procedure code.

MA53 Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.

MA92 Missing/incomplete/invalid plan information for other insurance.

Deactivated Remark Codes:

None

Claim Adjustment Reason Code Changes - 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 changes, additions, modifications, and retirement of reason codes. The updated list is posted three times per year, after each meeting, and the list may be found at: ***www.wpc-edi.com/codes/Codes.asp***. The committee approved the following reason codes as new codes as of February 2004:

Code	Current Narrative
161	Provider performance bonus
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks code for specific explanation.

Update of Health Care Claims Status Codes and Health Care

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

Medlearn Matters Number: MM3361
Related Change Request (CR) #: 3361
Related CR Release Date: July 23, 2004
Related CR Transmittal #: 230
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects all providers.

Provider Action Needed

Impact to You - The Health Insurance Portability and Accountability Act (HIPAA) requires all payers to use the applicable health care claims status category codes and health care claim status codes.

What You Need to Know - Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277.

What You Need to Do - Providers will need to be aware of the new codes that may appear on their response to a claims status inquiry.

Background

Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277. Under HIPAA, all payers must use health care claims status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee.

At each X12 trimester meeting (generally held in the months of February, June and October) the Committee may update the claims status category codes and health care claim status codes. Included in the code list are specific details, such as the date a code was added, changed, or deleted.

Per HIPAA (1996), health plans must be able to conduct the standard electronic transactions mentioned in the regulation. The named HIPAA transaction for claims status is the ASC X12N 276/277 4010A1 Health Care Claim Status Request and Response. The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes.

Medicare contractors are already using these code sets because of prior instructions. However, recently some new codes and code changes were made with the designation "new as of 2/04." Medicare carriers and intermediaries will start using the "new as of 2/04" codes as of January 3, 2005.

Additional Information

Claims Status codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-2, STC10-2 and STC11-2 composite elements. They indicate the detail about the general status communicated in the Claims Status Category Codes carried in STC01-1, STC10-1 and STC11-1. **Claims status codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid.**

For users who are new to the Claim Status transaction, please review the 276/277 Implementation Guide for using claim status codes. **The Claim Status transaction is not used as a financial transaction.**

Claim Status Category codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-1, STC10-1 and STC11-1 composite elements. They indicate the general category of the status (accepted, rejected, additional information requested, etc.), which is then further detailed in the Claim Status Codes carried in STC01-2, STC10-2 and STC11-2.

The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes found at: ***www.wpc-edi.com/codes/codes.asp***. By January 3, 2005, Medicare carriers and intermediaries must have all applicable code changes and new codes that are posted on the Web site with the "new as of 2/04" designation and prior dates available for use in production.

The official instruction issued to your carrier regarding this change may be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. From that Web page, look for CR 3361 in the CR NUM column on the right, and click on the file for that CR.

Use of the 835v4010A1 Electronic Remittance Advice

The need for providers to begin using the American National Standards Institute (ANSI) X12N 835 version 4010A1 Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic remittance advice is imminent. Please note that once the HIPAA contingency plan is no longer in effect, the receivers who are not yet in production status will automatically be sent the ANSI X12N 835 version 4010A1.

The good news is that providers are not required to test with a Medicare contractor prior to acceptance of the ANSI 835 transactions. They simply need to inform the Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department of when they want transmission of the ANSI 835 to begin. If you are a current submitter, you need to send on company letterhead a brief statement that you want to switch from the National Standard Format (NSF) to the ANSI version of the electronic remittance advices (ERAs). If you are a new submitter, all you will need to do is fill out and fax the ERA Addendum, which can be found on the DMERC A Web site at: ***www.umd.nycpic.com/ern_agreement.html***. The EDI Department's fax number is 570-735-9510.

For your convenience, DMERC A EDI compiled a list of vendors who have successfully passed the 837 transaction with DMERC A. These vendors are approved for submission of the 837 transaction and may offer 835 interpretation software for the ANSI 835 transaction. You will find this listing on our Web site at: ***www.umd.nycpic.com/edidocfiles.html***.

Revised American National Standards Institute X12N 837 Professional Health Care Claim Companion Document

Medlearn Matters Number: MM3177
Related Change Request (CR) #: 3177
Related CR Release Date: April 23, 2004
Related CR Transmittal #: 73
Effective Date: May 24, 2004
Implementation Date: May 24, 2004

The following information affects physicians, suppliers, and providers.

Provider Action Needed

Impact to You - Physicians, suppliers, and providers should note that this instruction provides revisions to the American National Standards Institute (ANSI) X12N 837 Professional Health Care Claim Companion Document.

What You Need to Know - The revisions to the ANSI X12N 837 Professional Health Care Claim Companion Document correct errors and omissions in the Companion Document provided previously by Change Request (CR) 2900, Transmittal 29, dated December 19, 2003.

What You Need to Do - Refer to the *Background* and *Additional Information* sections of this instruction for further details regarding these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directed the Secretary of the Department of Health and Human Services (HHS) to adopt standards for transactions to enable health information to be exchanged electronically, and the Administrative Simplification Act (ASA), one of the HIPAA provisions, requires standard formats to be used for electronically submitted health care transactions.

The American National Standard Institute (ANSI) developed these, and the ANSI X12N 837 Implementation Guide has been established as the standard of compliance for claim transactions.

A Companion Document is defined as a set of statements, which supplements the X12N 837 Professional Implementation Guide, and it clarifies contractors' expectations regarding data submission, processing, and adjudication.

This instruction revises the X12N 837 Professional Health Care Claim Companion Document and corrects errors and omissions in the Companion Document (previously provided by Change Request (CR) 2900, Transmittal 29, dated December 19, 2003). This instruction also provides additional language to the Companion Document to cover items not previously addressed.

Also note that the Companion Document supplements, but does not contradict, requirements in the X12N 837 Professional implementation guide. A summary of changes to the document includes the following:

- Addition of a new statement indicating *"All diagnosis codes submitted on a claim must be valid codes per the qualified code source. Claims that contain invalid diagnosis codes, pointed to or not, will be rejected;"*
- Addition of two negative value statements for the 2400 loop (SV102 and CR102/CR106) which were omitted from the previous document;
- Revision to the calendar date statement, which changes it from "should" to "must;"
- Revisions to the maximum CLM statement which allows your carrier to specify the actual [value] and changes "will" to "will/may;"
- Revisions to ISA06 and ISA08 statements which changes both from "required" to "optional;"
- Correction made to option B of modifier statement; and
- Removal of calendar date statement from 997 section.

The specific language provided in the Companion Document is based on recommendations/decisions made by the Electronic Data Interchange Functional Workgroup (EDIFWG). The EDIFWG consists of members from the Centers for Medicare & Medicaid Services (CMS), Part B contractors, and shared system maintainers.

You have the option of adding specific items not contained in this companion document. However, these items must not contradict any other items in the companion document or in the X12N 837 Professional Implementation Guide.

To view the actual details of the changes for this Companion Document, please see the additional information section for instructions on how to access the official CMS instruction issued to your carrier.

Implementation

The implementation date for this instruction is May 24, 2004.

Additional Information

The official instruction issued to your carrier regarding this change may be found at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. From that web page, look for CR3177 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Also, implementation guides for all transactions are available electronically for each transaction at the following Web site: ***www.wpc-edi.com***

Reporting Medicare Secondary Payer Information on the Health Insurance Portability and Accountability Act of 1996 X12N 837, Created Via the Free Billing Software

Medlearn Matters Number: MM3284
Related Change Request (CR) #: 3284
Related CR Release Date: May 28, 2004
Related CR Transmittal #: 84
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

The following information affects all providers who use free billing software from Medicare for Health Insurance Portability and Accountability Act of 1996 (HIPAA) 837.

Provider Action Needed

Impact to You - All providers who use free (or low cost) billing software from Medicare for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 837 must receive a software upgrade related to Medicare Secondary Payer (MSP) from their carrier, durable medical equipment regional carrier, or intermediary. Changes included in the updated software will be required for electronic submission of such claims (when there is one primary payer to Medicare). **Note that the HIPAA 837 does not accommodate the data Medicare needs when there is more than one primary payer. Providers must submit these types of MSP claims to Medicare on paper.**

What You Need to Know - Please be sure to submit claims in the correct format to avoid delays in claims processing.

What You Need to Do - If you use the billing software supplied by a Medicare carrier or intermediary, please obtain the required software upgrade after October 4, 2004, from your carrier/intermediary to ensure accurate electronic claims processing.

Additional Information

If you have questions regarding this issue, contact your carrier or intermediary on their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll free number for your carrier/intermediary may be found online at: ***www.cms.hhs.gov/providers/edi/anum.asp***

If you bill for Medicare Part B services, the toll-free number may be found at: ***www.cms.hhs.gov/providers/bnum.asp***

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via Change Request Number (CR NUM) 3284, at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. Once at that page, scroll down the CR NUM column on the right to find CR3284 and click on the file for that CR.

DMERC A Submitters:

The billing software provided by the Region A Durable Medical Equipment Regional Carrier (DMERC A) is compliant with these instructions. No further action is needed at this time.

ExpressPlus Software, Version 4.2.3 Upgrade Now Available

Mandatory Use of Current Version

The latest version upgrade for the Medicare Low Cost Billing Software offered by the Region A Durable Medical Equipment Regional Carrier (DMERC A) was available as of August 2, 2004. **Version 4.2.3** of ExpressPlus can be obtained by download from the DMERC A Web site at: ***www.umd.nycpic.com/edisoftware.html#Upgrade***.

The Centers for Medicare & Medicaid Services (CMS) instructions to contractors, issued on July 26, 2004, **require** that only the most current Health Insurance Portability and Accountability Act (HIPAA)-compliant free-billing software be used. Therefore, this article serves as notification to all users of the Region A DMERC Low Cost Billing Software that **only ExpressPlus, Version 4.2.3 or higher can be used as of October 31, 2004**. The use of all other versions of ExpressPlus (4.2.1 or lower) **must be discontinued prior to October 31, 2004**.

Contact the DMERC A Electronic Data Interchange (EDI) Department toll-free at 866-861-7348 with questions or if you experience problems downloading the upgrade.

Where Does Your Vendor, Clearinghouse, or Other Third-party Biller Stand in Terms of HIPAA Compliance?

Providers who are **not** submitting HIPAA-compliant claims transactions will face significant problems once Medicare's contingency plan is terminated. It is crucial to assure your third-party partner's readiness to avoid significant problems.

Providers may take certain steps to assure that they AND their partners are ready. Check with your clearinghouse, vendor, or other third-party biller and do the following:

- Ask them about their readiness.
- Ask them how they have determined their readiness.
- Make sure they are aware of the Medicare contingency plan and the modification announced on February 27, 2004.
- If your agent indicates that the Medicare contingency plan (as outlined in Change Request (CR) 2981) will affect your claims, ask them when they will correct the problem, so your claims are eligible for prompt payment, and ask when that will happen.

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

Understand When Your Vendor, Clearinghouse, or Other Third-party Biller Will Stop Accepting Non-compliant Transactions

Even though the Centers for Medicare & Medicaid Services (CMS) implemented a contingency plan on October 16, 2003, that allows Medicare providers, suppliers, and other electronic billers to continue sending pre-Health Insurance Portability and Accountability Act (HIPAA) formats, that plan is not binding on other entities. At any time, vendors, clearinghouses, and other third-party billers could decide to limit or discontinue supporting pre-HIPAA formats. We encourage providers and suppliers using a third-party entity for sending their electronic claims to work closely with that entity to understand the HIPAA electronic claims requirements. Verify that you are submitting the data required under HIPAA and that your claims are being transmitted in the standard HIPAA format. In order to protect your interests and ensure **uninterrupted cash flow**, start working towards meeting the HIPAA standard requirements now.

HIPAA Compliance Update

More than ninety percent (90%) of all electronic Medicare claims submitted to the Region A Durable Medical Equipment Regional Carrier (DMERC A) are now Health Insurance Portability and Accountability Act (HIPAA) compliant. If you are sending HIPAA-compliant claims, DMERC A thanks you. If you are **not** currently submitting HIPAA-compliant claims, DMERC A strongly encourages you to contact your vendor today and become HIPAA-compliant as soon as possible.

HIPAA compliance is mission critical! Think of all the benefits of submitting electronically: Medicare claims submitted electronically are filed faster, more efficiently, and more cost-effectively than paper claims. If you do not bill claims electronically, consider the following advantages of electronic data interchange (EDI).

- 14-day payment floor vs. 27-day payment floor for paper claims and non-HIPAA compliant claims.
- Increased accuracy and minimized rejections. Direct processing; i.e., processors do not re-key the claims.
- Availability of Electronic Remittance Advice (ERA) for faster posting.
- Online claim status verification (for more information on this, visit our Web site at: ***www.umd.nycpic.com/olcs.html***).
- Electronic Certificates of Medical Necessity (CMNs).
- Ability to submit claims seven (7) days a week, including holidays.
- A unit dedicated solely for EDI support for faster problem resolution.

Miscellaneous

Reminder to Providers to Supply Information to Medicare's Comprehensive Error Rate Testing (CERT) Program

Medlearn Matters Number: MM2976
Related Change Request (CR) #: 2976
Related CR Release Date: February 27, 2004
Related CR Transmittal #: 67
Effective Date: March 12, 2004
Implementation Date: March 12, 2004

The following information affects all Medicare providers.

Provider Action Needed

Providers are reminded that they must comply with requests from Medicare contractors for medical records needed for the CERT program.

Background

The CERT program produces national, contractor-specific, and service-specific paid claim error rates, as well as a provider compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The provider compliance error rate is a measure of the extent to which providers are submitting claims correctly. The program uses independent reviewers to review representative random samples of Medicare claims (including both paid claims and denied claims) to ensure that the decision was appropriate.

The CERT process begins at the Affiliated Contractor (AC) — your Medicare carrier or intermediary processing site — where claims have entered the Medicare claims processing system. The CERT contractor randomly selects and extracts claims from the claims processing system each day. The CERT contractor obtains medical records from providers (or from the AC, if the AC had previously subjected the claim to manually medical review).

The CERT contractor requests medical records from providers in a written format, including a checklist of the types of documentation required. In addition, the CERT contractor follows up on written requests with phone calls to providers. Providers must submit documentation to the CERT Operations Center via fax or by mail at the number/address specified in the Additional Information section below.

Although providers are required to send documentation to support claims as part of the CERT process, many providers do not comply with this requirement. Providers may believe that it is a Health Insurance Portability and Accountability Act (HIPAA) violation to send patient records to CERT, they may not understand the CERT process, or they may not understand the importance of sending documentation in a timely fashion. It is, however, important to

respond in a timely fashion to CERT requests and to provide the CERT contractor with all applicable medical records used to support a sampled claim.

If providers do not respond to initial CERT requests for medial records, they will receive up to four letters and three phone calls from the CERT contractor. Providers who fail to submit medical documentation to the CERT contractor should expect to receive overpayment demand letters from their AC, as services for which there is no documentation are interpreted as services not rendered.

Additional Information

The fax numbers for the CERT contractor are:

804-864-3268;
804-864-9940; and
804-864-9979.

You can also mail documentation to:

AdvanceMed
CERT Operations Center
1530 E. Parham Road
Richmond, VA 23228

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

To learn more about the CERT program, you can view the manual instructions issued to your carrier/intermediary under CR 2976 by visiting:
www.cms.hhs.gov/manuals/pm_trans/R67PI.pdf

Recently, the Centers for Medicare & Medicaid Services (CMS) issued additional clarifications (CR3229) to your carrier/intermediary. To view these clarifications, visit:
www.cms.hhs.gov/manuals/pm_trans/R77PI.pdf

To find future CERT manual instructions issued to your carrier/intermediary, visit:
www.cms.hhs.gov/manuals/108_pim/pim83c12.pdf

Reminder: KX Modifier Study

A study is being conducted by the Region A Program Safeguard Contractor (PSC), TriCenturion, as part of their responsibilities under the Comprehensive Error Rate Testing (CERT) initiative. Providers are encouraged to respond to requests from the PSC. For more information, refer to the article "KX Modifier Study" on the "What's New" page of the PSC Web site at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

MMA - National 1-800-MEDICARE (1-800-633-4227) Implementation (Section 923(d) of MMA)

Medlearn Matters Number: MM3195
Related Change Request (CR) #: 3195
Related CR Release Date: April 30, 2004
Related CR Transmittal #: 159
Effective Date: June 1, 2004
Implementation Date: June 1, 2004 (Start Date of phased implementation that should be completed on August 1, 2004. - ***NOTE*: The completion date has been extended to August 15, 2004.**)

The following information affects all providers.

Provider Action Needed

Impact to You - Medicare carriers (including DMERCs) and fiscal intermediaries will no longer maintain their own individual **beneficiary** toll-free telephone numbers. Instead, all beneficiary calls should be directed to 1-800-MEDICARE (1-800-633-4227).

What You Need to Know - Effective June 1, 2004, carriers and FIs will begin to transition to **1-800-MEDICARE (1-800-633-4227)** for all beneficiary questions that pertain to Medicare claims and services. The Centers for Medicare & Medicaid Services (CMS) will contact each carrier/FI on an individual basis to provide the specific migration/implementation date for that contractor (phase-in is planned for June - July 2004). As calls come in to the new centralized number, questions regarding specific claims will be routed to the appropriate Medicare carrier/FI for response.

What You Need to Do - Medicare carriers/FIs will publish the new beneficiary toll-free telephone number on Medicare Summary Notices (MSNs), beneficiary correspondence, Medicare Redetermination Notices (formerly, appeals letters) and, if applicable, on Medicare beneficiary Web sites. On or after August 1, 2004, **when you advise your patients to call Medicare with questions, direct them to 1-800-MEDICARE. However, for calls regarding**

eligibility status or claims status, and other provider-initiated inquiries, providers should continue to use the existing provider toll-free numbers. (***Note***: The DMERC A toll-free number is available on the back cover of this bulletin.)

Background

The change in policy, driven by the Medicare Modernization Act (MMA) of 2003 (section 923 (d)), requires all Medicare carriers/FIs to use one number—**1-800-MEDICARE (1-800-633-4227)**—for all Medicare questions from beneficiaries. By providing a single call-in number, Medicare aims to improve customer telephone service by connecting callers quickly with the correct Medicare contractor for their case and question, thereby reducing the number of calls and referrals overall.

Currently, an internal CMS workgroup is developing standard operating procedures for processes and exceptions to this new policy. All procedures will be communicated to contractors as soon as final decisions are made.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. From that web page, look for CR 3195 in the CR NUM column on the right, and click on the file for that CR number.

Also, remember that 1-800-MEDICARE is for beneficiary-initiated calls. Providers calling Medicare should continue using the numbers currently in use. If you do not have that number, you may find it at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Use of Group Health Plan Payment System for Demonstrations Serving Medicare Fee-For-Service Beneficiaries

Medlearn Matters Number: MM3283
Related Change Request (CR) #: 3283
Related CR Release Date: May 14, 2004
Related CR Transmittal #: 4
Effective Date: October 4, 2004
Implementation Date: October 4, 2004

The following information affects all Medicare providers.

Provider Action Needed

No action needed.

Background

The Centers for Medicare & Medicaid Services (CMS) is conducting several large coordinated care and disease management demonstrations under which private organizations will contract with CMS to provide disease management services to beneficiaries enrolled in the traditional Medicare Fee-For-Service program. In a previous Medlearn Matters article published on 5/13/2004 (SE0425), a summary of the Medicare Disease Management Demonstration was provided with an instruction to treat participants in the demonstration as traditional fee-for-service beneficiaries.

The Medicare beneficiaries participating in these demonstrations are NOT enrolled in an HMO. The Disease Management Organizations are being paid using the CMS Group Health Plan System as an "Option 1" cost plan. All fee-for-service claims will continue to be able to be processed under traditional Medicare payment rules and beneficiaries enrolled in these demonstrations will be considered covered under the traditional Medicare Fee-For-Service program.

Beneficiaries will only receive coordinated care/disease management services from these special demonstration plans. They are not restricted in any way as to how they receive their other Medicare services.

In order to avoid confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on certain standard system screens, the related CR 3283 directs CWF to suppress any reference to HMO information on certain screens for beneficiaries enrolled in these demonstrations.

MMA - Medicare Replacement Drug Demonstration

Medlearn Matters Number: SE0443

Related Change Request (CR) #: N/A
Effective Date: Immediately
Implementation Date: Immediately

The following information affects all Medicare physicians and providers.

Provider Action Needed

Impact to You - A new demonstration mandated under Section 641 of the Medicare Modernization Act lets up to 50,000 people with Medicare who have certain life-threatening diseases obtain specified drugs they can take themselves at home for their condition.

What You Need to Know - A physician certification will need to be filled out for any of your patients who are interested in applying to participate in this demonstration. By signing this certification, you are certifying that the patient has the condition indicated and you have prescribed or intend to prescribe a coverable drug for this condition in accordance with the demonstration requirements. Your signed certification is necessary for the patient's application to participate in the demonstration to be considered complete.

What You Need to Do - Review the list below of coverable conditions and drugs available under this demonstration. If you have any patients you think might be interested and eligible to apply, let your patients know. If they have any questions about the demonstration, they can call a toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387) or visit our Web site (***www.medicare.gov***) for more information or an application package. In addition, if any of your patients contact you about the demonstration and the required physician certification form, please complete the form in a timely manner. Enrollment in the demonstration is limited and all applications must be received by September 30, 2004, to be considered. Those who have submitted completed applications by August 16, 2004, may be eligible for coverage by September 1, 2004. An application is not considered complete without the physician certification form, so your prompt attention is appreciated.

Background

The Medicare Replacement Drug Demonstration is a time-limited Medicare demonstration that will cover certain drugs and biologicals that are prescribed as replacements for existing covered Medicare drugs and biologicals before Medicare's prescription drug program begins in 2006. This demonstration was authorized by Section 641 of the Medicare Modernization Act.

The Centers for Medicare & Medicaid Services (CMS) has contracted with TrailBlazer Health Enterprises, a Medicare carrier, to assist in implementing the demonstration. TrailBlazer will manage the eligibility determination and enrollment process as well as coordinate outreach efforts to beneficiary advocacy groups, physicians, and others interested in this demonstration. TrailBlazer has sub-contracted with AdvancePCS, a Caremark company, to administer the drug benefit.

Medicare realizes the important role drugs play in treating serious diseases.

When Medicare first began, drugs played a much smaller role in medical care. Only drugs that are administered in a physician's office have been covered under Medicare Part B. In recent years, many new medications have been developed that replace some of these drugs, allowing patients with serious and lifethreatening illnesses to take these drugs in their own home.

For a beneficiary to be eligible for this demonstration, he or she must meet the following criteria:

- The beneficiary must have Medicare Part A and Part B.
- Medicare must be the beneficiary's primary health insurance.
- The beneficiary must reside in one of the 50 states or the District of Columbia.
- The beneficiary must have a signed certification form from his or her doctor stating that he or she has prescribed or intends to prescribe for the beneficiary one of the covered medications for the specified condition.
- The beneficiary may not have any other insurance that has comprehensive drug coverage (such as Medicaid, an employer or union group health plan, or TRICARE) that would cover this medication.

The table below shows the drugs and conditions that will be covered under the demonstration.

Drugs Covered Under the Medicare Replacement Drug Demonstration

Demonstration Covered	Indication Drug/Biological—Compound Name (Brand Name)
Rheumatoid Arthritis	Adalimumab (Humira) Anakinra (Kineret) Etanercept (Enbrel)
Multiple Sclerosis	Glatiramer acetate (Copaxone) Interferon beta –1a (Rebif, Avonex) Interferon beta –1b (Betaseron)
Osteoporosis (patient must be homebound)	Calcitonin – nasal (Miacalcin – nasal)
Pulmonary Hypertension	Bosentan (Tracleer)
Secondary Hyperparathyroidism	Doxercalciferol (Hectoral)
Paget's Disease	Alendronate (Fosamax) Risedronate (Actonel)
Hepatitis C	Pegylated interferon alfa-2a (Pegasys) Pegylated interferon alfa-2b (PEG-Intron)
CMV Retinitis	Valcyte (Valganciclovir)
Anti-Cancer	
• Cutaneous T-cell Lymphoma	Bexarotene (Targretin)
• Non-small cell lung cancer	Gefitinib (Iressa)
• Epithelial ovarian cancer	Altretamine (Hexalen)
• Chronic Myelo-genous Leukemia	Imatinib Mesylate (Gleevec)
• GI Stromal Tumor	Imatinib Mesylate (Gleevec)
• Multiple Myeloma	Thalidomide (Thalomid)
Breast Cancer • Stage 2-4 only	Hormonal therapy Anastrozole (Arimidex) Exemestane (Aromasin) Letrozole (Femara) Tamoxifen (Nolvadex) Toremifene (Fareston)

For more information on this demonstration please visit ***www.medicare.gov*** or call our toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387) between 8 am and 7:30 pm Eastern time, Monday – Friday. (***Note***: A revised version of this article is currently available at: ***www.umd.nycpic.com/dmeduc.html***. That version will be published in the December 2004 *DMERC Medicare News*.)

Attention Suppliers: New Insurance Requirements

Effective August 1, 2004, the Centers for Medicare & Medicaid Services (CMS) will be requiring all suppliers to place the National Supplier Clearinghouse (NSC) as the certificate holder on their insurance policies. All new applications will be required to have this on the insurance certificate attached. All suppliers who already have a supplier number will be required to have this completed by the next re-enrollment or the next activity on the file that may cause the NSC to require a copy of the insurance policy. The address on file at the insurance company should be:

National Supplier Clearinghouse - AG-495
Palmetto GBA
PO Box 100142
Columbia, SC 29202-3142

The purpose of this is to ensure that, when a certificate of insurance is cancelled, the NSC is immediately notified that the supplier doesn't have the insurance they listed on file. The NSC will then be able to follow up with the supplier to obtain a new certificate from the new insurance company. That certificate should have the NSC as certificate holder also.

Updating Supplier Records

Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information **must** be reported in writing to the National Supplier Clearinghouse (NSC) **within 30 days** after such changes have taken place. Visit the NSC Web site (***www.palmettogba.com***), call the toll-free telephone number (866-238-9652), or write to the NSC (at the address below) for instructions.

National Supplier Clearinghouse (NSC)
NSC, AG-495
P.O. Box 100142
Columbia, SC 29202-3142

Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number. (*Note*: **The Region A Durable Medical Equipment Regional Carrier cannot change supplier files**.)

Program Inquiries

KX Modifier Reminder

Recent data analysis has shown there continues to be a high volume of appeal requests, where all that is

needed is for the **KX** modifier to be added. The **KX** modifier is to be billed with appropriate Healthcare Common Procedure Coding System (HCPCS) codes when all requirements described in the specific medical policy are met and all required documentation is available. The correct use of the **KX** modifier will ensure prompt and correct payment and decrease the number of cases that have to be submitted for an appeal.

Telephone Reviews and Surgical Dressings

Surgical dressings denied due to over utilization, missing modifiers, change in units billed, or change in procedure code **cannot** be completed as telephone reviews, since additional documentation is needed to adjudicate these claims properly. Instead, a written review request is required, along with additional documentation, in order for the appeals nursing staff to make the payment determination for the denied claims.

Appeal Request Reminder – Documentation

When submitting a claim for an appeal of any kind, it is important to include all the necessary documentation **at the time of the request** that you would like considered for review. This is especially important when billing miscellaneous codes. For example, make and model number, part number, manufacturer information, etc. would be required for miscellaneous codes.

Hearing Request Reminder – Type of Hearing

When requesting a hearing officer hearing, it is important that the **type of hearing requested**, either in-person, telephone, or on-the-record, is specified within the request. If the preferred type of hearing is **not** specified, a delay in the processing of your appeal may occur.

Current information on appeals and educational resources is available via the DMERC A Web site at:
www.umd.nycpic.com/dmeduc_main.html

Program Education & Training

Claim Submission Errors for the Third 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 April 1, 2004 through June 30, 2004, are provided in the following chart. The total number of ANSI errors for this period was **233,660**.

ANSI Error Number - Narrative (Total Errors)	**Reason for Error**
1) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question (40,110 errors)	The question number entered is not valid for the DMERC CMN you are sending
2) 40022 - Procedure Code/ Modifier Invalid (27,608 errors)	The procedure code and/or modifier used on this line is invalid.
3) 40073 - Dates of Service Invalid with Procedure (16,913 errors)	The procedure code used is not valid for the dates of service used.
4) 40094 - Non-oxygen claim missing required element (8,799 errors)	The CMN associated with this claim is missing required information.
5) 40037 - Service date greater than receipt date (8,272 errors)	Service date is greater than date claim was received.
6) 40036 - Service date does not equal "to" date (6,828 errors)	The procedure code submitted does not allow for spanned dates of service.
7) 40067 - Invalid/Unnecessary CMN Version Submitted (6,254 errors)	The DMERC CMN version number entered is not valid for

ANSI Error Number - Narrative (Total Errors)	Reason for Error
	the Healthcare Common Procedure Coding System (HCPCS) code submitted.
8) 40066 - Invalid/Unnecessary CMN Submitted (6,172 errors)	The DMERC CMN form number entered is not valid for the HCPCS code submitted.
9) 20193 - Invalid Carrier Code (6,020 errors)	Carrier code entered is not valid for the Region A DMERC.
10) 20025 - Subscriber ID Code Invalid (5,363 errors)	Subscriber ID code entered is not in a valid format.

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

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

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
1) CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure codes(s) and/or rates. (20,723 claims)	**Item 24D** - Enter the procedures, services, or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.
2) 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. (17,157 claims)	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.
	You may enter up to four codes in priority order (i.e., primary, secondary condition).
3) CO 16 M78 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid HCPCS modifier. (8,559 claims)	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable, show HCPCS modifiers with the HCPCS code.
4) CO 16 MA 83 Claim/service lacks information which is needed for adjudication. Did not indicate whether we are the primary or secondary payer. (7,819 claims)	**Item 11** - Enter the name of the enrollee in a Medigap policy if different from Item 2. Otherwise, write "SAME." If no Medigap benefits are assigned, leave blank. Item 11 **must** be completed. If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE."
5) CO 16 MA 102 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/supervising provider (5,559 claims)	**Item 17** - Enter the name of the referring or ordering physician. *AND/OR* **Item 17A** - Enter the physician Unique Physician Identification Number (UPIN) in Item 17A.
6) CO 16 MA82 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number. (4,700 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 per-

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
	forming provider of service/supplier who is a member of a group practice.
7) CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different. (4,607 claims)	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.
8) CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid place of service. (3,399 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.
9) CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid information on where the services were furnished. (2,998 claims)	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.
10) CO 16 M79 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid charge. (430 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. DMERC A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above charts, and share it with your colleagues!

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

- DMERC Bulletins
- DMERC A Web site/ListServes
- State Association Web sites/ListServes
- Durable Medical Equipment Coding System (DMECS)
- WebEx Online Training
- Current Educational Outreach
- Future Educational Opportunities and Plans
- Data Analysis
- CMS Change Requests (CR) Important Updates and Reminders
- Comprehensive Error Rate Testing (CERT)
- Health Insurance Portability and Accountability Act (HIPAA)

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, 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 page or contact the PET Department at 570-735-9666, and select **option 1**.

Spring 2004 Educational Seminars in Retrospect

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department completed a very successful round

of seminars during the spring of 2004. A total of 24 seminars were conducted throughout our ten-state region, reaching approximately 1,200 providers within our service area. Topics included DMERC 101/Documentation, Medicare Program Billing Updates, Parenteral and Enteral Nutrition Billing, and Respiratory Billing.

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

Seminar attendees are asked to complete an evaluation form at the end of each educational session. Among other things, the form asks participants to respond to their overall satisfaction. The overall satisfaction rate for the spring 2004 seminars was 95% for Met/Exceeded expectations. Participant comments included:

- *"This was an excellent opportunity to learn. Nice job."*
- *"Excellent presentation. Thanks for your time and cooperation."*
- *"Took extra time to explain content. Thanks!"*
- *"Seminar was well spoken and well presented."*
- *"Information given has been very informative. I look forward to other seminars."*
- *"Thank you for being so informative."*

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

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

Providers should check the "Events" section of our Web site for announcements and schedules of upcoming seminars and outreach events, including our new Web-based seminars, for the fall of 2004.

Fall 2004 Seminars

The Region A Durable Medical Equipment Regional Carrier (DMERC A) announces the fall 2004 continuing education seminars. These sessions are being offered at **no charge**. Topics for the sessions include DMERC 101, Documentation, and Medicare Billing Updates. Please visit the "Events" section of the DMERC A Web site (***www.umd.nycpic.com/dmprovcaln.html***) for more information, including details on what will be covered in each session.

Dates and Locations

Date	Location	Address/Telephone
October 12, 2004	Holiday Inn Stamford	700 Main Street Stamford, CT 203-358-8400
October 14, 2004	Holiday Inn Ithaca	222 South Cayuga Street Ithaca, NY 607-272-1000
October 19, 2004	Wyndham Hotel Mount Laurel	1111 Route 73 Mount Laurel, NJ 856-234-7000
October 21, 2004	Wyndham Hotel Harrisburg/ Hershey	4650 Lindle Road Harrisburg, PA 717-564-5511

Note: **Please contact the hotels directly for information regarding overnight accommodations, parking, and driving directions.**

Please visit the "Events" section of our Web site (***www.umd.nycpic.com/dmprovcaln.html***) for complete information on seminar times and course agendas.

How to Register

All attendees **must** be registered in advance. **You may now submit your registration online.** The registration form is available via the DMERC A Web site. **Registrations are due no later than one week prior to the seminar (registrations will not be accepted at the seminars).** 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.

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 sent to you.

Attention All Suppliers Who Want to Save Time and Money!

Do you want to train your staff without the hassle of leaving the office? If so, visit the "Education - Tutorials" section of the Region A Durable Medical Equipment Regional (DMERC A) Web site at: ***www.umd.nycpic.com/dme-eduonline.html***. Online tutorials are now available for viewing 24 hours per day, seven days a week. The following topics are available:

- Advance Beneficiary Notice (ABN)
- Capped Rental Modifiers
- DMEPOS Payment Categories
- DMERC Forms that Relate to Medical Necessity
- DMERC Resources
- Remittance Notices

The following topics are scheduled for the near future:

- Appeals Process
- How to Use the Automated Response Unit (ARU)
- Pharmacy Billing
- Refractive Lens (Vision) Billing

Do you want the interaction of a live seminar without leaving your office? Then, visit the "Events" section at: ***www.umd.nycpic.com/dmprovcaln.html***. Live online sessions were recently presented for the following topics:

- DMERC 101
- Documentation
- Respiratory
- Parenteral Nutrition
- Enteral Nutrition

Further tutorials and live sessions will be forthcoming.

Web Site Resources

DMERC A ListServes

Want to be on the cutting edge? Want to be the first to know? Don't have time to check the Web site for updates?

Join the Region A Durable Medical Equipment Regional Carrier (DMERC A) ListServes! All you need is Internet access and an email address. Plus, it's free and it's easy. Let us help you stay informed!

What are the benefits of joining the DMERC A ListServes? By joining, you will be the first to know important and time-sensitive Medicare program information and all other important or urgent announcements. You will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly bulletins become available.

DMERC A currently offers three ListServes:

- **DMERC A ListServe** - For general Medicare program information and information regarding DMERC A Web site updates.
- **Supplier Manual ListServe** - For notification of *DMERC A Supplier Manual* revisions.
- **EDI ListServe** - For electronic data interchange (EDI) information as it pertains to the way you and your clients do business with DMERC A.

New, specialty ListServes will include: Drugs; Mobility/Support Surfaces; Orthotics & Prosthetics; Oxygen; Parenteral/Enteral Nutrition; Specialty Items; and Vision. These specialty/area of interest ListServes mirror the article designations found in the Table of Contents section of the quarterly bulletins (refer to the front cover), and they enable DMERC A to send targeted information to specific supplier/provider audiences.

Signing up for the DMERC A ListServes gives you immediate notification of important information on Medicare changes impacting your business. We encourage all providers to be part of the "in crowd" and join today at: ***www.umd.nycpic.com/dmlistserve.html***.

Providers should also subscribe to the Region A Program Safeguard Contractor (PSC) ListServe by visiting:
www.tricenturion.com/content/whatsnew_dyn.cfm.

Supplier Manual News

The Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier manual is available via the "Publications" section of our Web site at: ***www.umd.nycpic.com/dmprovpublcopy.html***. After accepting the CPT License Agreement, suppliers can access the entire *DMERC A Supplier Manual*.

The *DMERC A Supplier Manual* is **only** available to current suppliers via the DMERC A Web site. Newly enrolled suppliers will continue to receive initial hardcopy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS).

Corrections/updates have been made to the manual:

Revision 2003-02 (December 2003)

- Chapter 1 (Contact Information) - direct zip codes added for post office box addresses; Electronic Data Interchange (EDI) Help Desk telephone number replaced by toll-free number
- Chapter 3 (Health Insurance Claim Form) - Medicare Carriers Manual (MCM) references updated with CMS Online Manual System references; information on ordering claim forms revised to reflect current process
- Chapter 4 (Electronic Data Interchange) - MCM references updated with CMS Online Manual System references; EDI Help Desk telephone number replaced by toll-free number
- Chapter 9 (Durable Medical Equipment) and Chapter 10 (Program Safeguard Contractor) - MCM references updated with CMS Online Manual System references

Revision 2003-03 (March 2004)

- Chapter 9 (Durable Medical Equipment) - proof of delivery information updated to reflect information from Change Request (CR) 2903 (Transmittal 61)

Revision 2003-04 (June 2004)

- Chapter 1 (Contact Information) - Program Inquiries Voice Mail number removed (no longer available); other DMERC Offices updated to reflect current information
- Chapter 3 (Health Insurance Claim Form) - multiple areas revised to reflect various CMS manual changes
- Chapter 10 (Program Safeguard Contractor) - multiple areas revised to reflect various CMS manual changes; information added regarding the Comprehensive Error Rate Testing (CERT) initiative

Revision 2003-05 (July 2004)

- Chapter 4 (Electronic Data Interchange) - multiple areas revised to reflect various HIPAA and CMS manual changes; information added regarding DMERC A ListServes
- Chapter 9 (Durable Medical Equipment) - multiple areas revised to reflect various CMS manual changes

  (***Note***: The table of contents was updated under revisions 2003-02, 2003-04, and 2003-05.)

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

Region A Provider Information

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

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

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services on the first business day of each quarter. It is a listing of all non-regulatory changes to

Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The Quarterly Provider Update can be accessed at: ***www.cms.hhs.gov/providerupdate***. We encourage you to bookmark this Web site and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update ListServe at: ***list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1***

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

SADMERC Durable Medical Equipment Coding System (DMECS)

Recently introduced by the Statistical Durable Medical Equipment Regional Carrier (SADMERC), DMECS is an online application that provides Healthcare Common Procedure Coding System (HCPCS) coding assistance and national pricing information 24 hours a day. DMECS is designed to help Medicare providers and suppliers quickly classify durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) by combining information from a variety of sources to make HCPCS coding determinations for claim submission to the DMERCs easier.

Phase 1 of DMECS includes an HCPCS and fee schedule look-up with capabilities to print or download information. Future enhancements will include SADMERC Classification Lists, sample product pictures, and a coding navigator tool that categorizes and combines HCPCS codes in a format that allows you to easily determine how to code your product.

Your feedback is vital to the success of this tool. You may access DMECS by selecting "SADMERC" from the Palmetto GBA home page at: ***www.palmettogba.com***

Medlearn Fact Sheets

The Centers for Medicare & Medicaid Services has made the following information available for providers.

Medicare Secondary Payer Fact Sheets

Four fact sheets are available on the ***Medlearn*** Web page at: ***www.cms.hhs.gov/medlearn/pubs.asp***. These fact sheets should prove to be very useful in explaining provider/billing clerk responsibilities. The fact sheets are titled as follows:

- ***'Collecting, Submitting, and Updating Beneficiary Insurance Information For Clinical Laboratories';***
- ***'Complying with Medicare Secondary Payer Requirements';***
- ***'Collecting, Submitting, and Updating Beneficiary Insurance Information to Medicare'; and***
- ***'When Medicare is the Primary Payer.'***

Revised Fact Sheets on Long Term Care Hospital Prospective Payment System

Revised fact sheets are now available on the Medicare Learning Network Web site at ***www.cms.hhs.gov/medlearn/ltchpps.asp***. The fact sheets are (**Revised: June 2004**):

- Updated Final Rule Fact Sheet (pdf format 483Kb)
- Short-Stay Outliers Fact Sheet (pdf format 466Kb)
- Interrupted-Stay Fact Sheet (pdf format 828Kb)
- High Cost Outliers Fact Sheet (pdf format 835Kb)

Rural Health Fact Sheets

Four new Fact Sheets that contain rural health information, definitions, helpful rural health resources, and Medicare Prescription Drug, Improvement and Modernization Act of 2003 enhancements (if applicable) are now available on the Medicare Learning Network Web site at ***www.cms.hhs.gov/medlearn/pubs.asp***. The Fact Sheets are entitled:

- Rural Health Clinic
- Sole Community Hospital
- Federally Qualified Health Center
- Critical Access Hospital Program

The Pulse of CMS

The Centers for Medicare & Medicaid Services (CMS) provided DMERC A with a copy of the Summer 2004 edition of "The Pulse of CMS." This quarterly regional publication is available via the "Education - Articles and Publication Highlights" section of our 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.)

Telephone Numbers

Caller Information Network	
Supplier Toll-Free Line	866-419-9458
Beneficiary Toll-Free Line	1-800-MEDICARE (1-800-633-4227)
EDI Services Help Desk	866-861-7348
Program Education & Training	570-735-9666
Program Inquiries	
Telephone Reviews Line	866-420-6906
FAX Numbers	
Check Control/MSP	570-735-9594
Electronic Data Interchange	570-735-9510
Extra Documentation	570-735-9402
Program Education & Training	570-735-9442
Program Inquiries (Hearings & Reconsideration)	570-735-9599
National Supplier Clearinghouse	866-238-9652
SADMERC	877-735-1326

Web Sites

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

Addresses

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

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