DMERC A Medicare News

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

Articles are identified by area of interest as follows:
DRU = Drugs, **GEN** = General, **MOB** = Mobility/Support Surfaces, **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

News from CMS…

Instructions for Pricing Treprostinil (Q4077)

Medlearn Matters Number: MM3533
Related Change Request (CR) #: 3533
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 123
Effective Date: January 1, 2004
Implementation Date: November 29, 2004

The following information affects all Durable Medical Equipment (DME) suppliers.

Provider Action Needed

Impact to You

Medicare's Durable Medical Equipment Regional Carriers (DMERCs) will use the specific payment for Healthcare Common Procedure Coding System (HCPCS) drug code Q4077 (Treprostinil) located in the 2004 Medicare Modernization Act of 2003 (MMA) Payment Limits Pricing File.

What You Need to Know

The 2004 pricing allowance for Q4077 is $61.75.

What You Need to Do

Make sure that your billing offices are aware of this instruction.

Background

This article and the related change request advise suppliers that the DMERCs will use the 2004 MMA Payment Limits Pricing File when pricing the drug Treprostinil (Q4077). That 2004 pricing allowance for Q4077 is $61.75 and is effective for claims with dates of service on or after January 1, 2004. This change will ensure consistency among the four regional DMERCs and continuity of care for Medicare beneficiaries requiring Treprostinil.

NOTE: The DMERCs will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

Implementation

The implementation date is November 29, 2004.

Related Instructions

The 2004 MMA Payment Limits Pricing File is available at: ***www.cms.hhs.gov/providers/drugs/default.asp***

Additional Information

The official instruction issued to your DMERC regarding this change may be found at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

From that Web page, look for CR 3533 in the CR NUM column on the right and click on the file for that CR. If you have any questions, please contact your DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Drugs Paid by Average Selling Price Beginning January 1, 2005

Medlearn Matters Number: MM3232
Related Change Request (CR) #: 3232
Related CR Release Date: December 16, 2004 **Revised**
Related CR Transmittal #: 397
Effective Date: January 1, 2005
Implementation Date: January 3, 2005
Note: This article was revised on December 16, 2004, to reflect revised effective and implementation dates. Related CR 3232 was also reissued on December 16 for the same purpose.

The following information affects physicians, suppliers, and providers.

Provider Action Needed

Physicians, suppliers, and providers should note that beginning January 1, 2005, the payment limit for Part B drugs and biologicals, not paid on a cost or prospective payment basis, will be paid based on the Average Sales Price (ASP) plus six (6) percent. Drugs will be paid based on date of service and the lower of:

1) The submitted charge; **or**
2) The ASP plus six (6) percent.

Background

According to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), beginning January 1, 2004, through December 31, 2004, drugs and biologicals not paid on a cost or prospective payment basis are paid based on various standards specified in the statute, although the default payment limit standard is 85 percent of Average Wholesale Price (AWP).

MM3232 notifies contractors (Part B Local Carriers and Durable Medical Equipment Regional Carriers (DMERCs)) that the MMA mandates that drugs and biologicals not paid on a cost or prospective payment basis are to be paid based on the ASP beginning January 1, 2005.

Therefore, beginning January 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will:

- Supply contractors with a drug payment limit file for drugs and biologicals; and
- Send quarterly updates of this file to contractors.

Payment will be based on:

- The lower of the submitted charge or the payment limit on this file; and
- The date-of-service.

Finally, contractors will:

- Develop payment limits when CMS does not supply a payment limit for the drug on the file;
- Continue to determine the payment limit for compounded drugs; and
- Continue to determine the payment limit for new drugs.

Implementation

The implementation date for this instruction is January 3, 2005.

Related Instructions

The *Medicare Internet Only Manual* (IOM) has been edited with revised and new sections to reflect changes implemented with this instruction. These revised and new sections include the following:

The *Medicare Claims Processing Manual (Pub. 100-4), Chapter 17 (Drugs and Biologicals)*:

- Section 10 (Payment Rules for Drugs and Biologicals) – **revised**
- Section 20 (Payment Allowance Limit for Drugs and Biologicals Not Paid on a Cost or Prospective Payment Basis) – **revised**
- Subsection 20.1 (MMA Drugs) - **new**

These revised and new sections of the Medicare Claims Processing Manual are included in the actual instruction (CR 3232) issued to your carrier or DMERC.

Additional Information

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

From that Web page, look for CR 3232 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2005

Medlearn Matters Number: MM3539
Related Change Request (CR) #: 3539
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 348
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects all providers.

Provider Action Needed

No provider action is necessary. This article is informational only and explains how Medicare pays for certain drugs that are not paid on a cost or prospective payment basis, effective January 1, 2005.

Background

According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the Average Sales Price (ASP) plus six (6) percent. The Centers for Medicare & Medicaid Services (CMS) will

supply its carriers/intermediaries with the ASP drug pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers.

Thus, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions

There are exceptions to this general rule, as summarized below:

1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the durable medical equipment is implanted. The payment allowance limits will not be updated in 2005.
3. The payment allowance limits for influenza, pneumococcal, and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
4. The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.

Note that the absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit in the ASP files does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Implementation

The implementation date is January 3, 2005.

Additional Information

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

From that Web page, look for CR 3539 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

Revisions to January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File

Medlearn Matters Number: MM3695
Related Change Request (CR) #: 3695
Related CR Release Date: January 13, 2005
Related CR Transmittal #: 134
Effective Date: January 1, 2005
Implementation Date: January 18, 2005

The following information affects providers who bill fiscal intermediaries and carriers (including Durable Medical Equipment Regional Carriers (DMERCs)) for the affected drugs.

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) is replacing payment limits for the first quarter of 2005 for certain Medicare Part B drugs, effective January 1, 2005.

What You Need to Know

The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. Please note that the related Change Request (CR) 3695 makes revisions to the earlier CR 3539 and that the revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document.

What You Need to Do

To ensure accurate claims processing, please review the

information included here and stay current with guidelines on Medicare Part B drugs and biologicals.

Background

Section 303(c) of the Medicare Modernization Act (MMA) of 2003 revises the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Effective January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the new Average Sale Price (ASP) drug payment methodology.

The ASP payment methodology is based on data submitted to CMS by manufacturers at the 11-digit National Drug Code (NDC) level. CMS uses published drug pricing compendia and other sources to identify the number of billable units per NDC.

Through receipt of additional data, CMS has determined that certain payment limits included in the first quarter of calendar year 2005 (1Q05) Medicare Part B Drug Pricing File require revision. The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. The revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document. The affected drugs and the associated revised payment limits are contained in the following table.

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90747*	ENGERIX-B	40 MCG	$113.91	$113.91
J0835	Inj cosyntropin per 0.25 MG	0.25 MG	$64.60	$64.60
J1563	IV immune globulin	1 GRAM	$56.72	$56.72
J1564	Immune globulin 10 mg	10 MG	$0.57	$0.57
J1655	Tinzaparin sodium injection	1000 IU	$2.60	$2.60
J2324	Nesiritide	0.25 MG (revised)	$73.33	$73.33
J3315	Triptorelin pamoate	3.75 MG	$180.93	$180.93
J3470	Inj hyaluronidase	up to 150 units	$20.00	$20.00
J7030	Sodium Chloride	1000 CC	$0.10	$0.10
J7350	Injectable human tissue	10 MG	$4.53	$4.53
J7611	Albuterol concentrated form	1 MG	$0.07	$0.07
J8501	Oral aprepitant	5 MG	$4.62	$4.62
J9185	Fludarabine phosphate inj	50 MG	$272.09	$272.09
J9214	Intron-A	1 UNIT	$13.12	$13.12
Q0179	Zofran	8 MG	$30.86	$30.86
Q2014	Geref	0.5 MG	$8.77	$8.77

*The revised payment limit for 90747 is based on the pricing methodology for vaccines (95% AWP).

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit in the ASP files does not indicate Medicare coverage of the drug or biological.

Additional Information

The official instruction issued regarding this change can be found at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down the CR NUM column on the right to find the link for CR 3695. Click on the link to open and view the file for the CR. You may also refer to the earlier CR 3539 for additional background information – CR 3695 makes revisions to information provided in CR 3539. If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

New Dispensing/Supply Fee Codes for Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, and Inhalation Drugs

Medlearn Matters Number: MM3620
Related Change Request (CR) #: 3620
Related CR Release Date: December 16, 2004 **Revised**
Related CR Transmittal #: 396
Effective Date: January 1, 2005
Implementation Date: January 17, 2005
Note: This article was revised on December 23, 2004, to show that the payment for code G0369 is a one-time payment per beneficiary, **per transplant**. The article was also revised on December 29, 2004, to show that beneficiaries are required to pay the normal co-pay and deductible on both the drug and the dispensing/supply fee.

The following information affects suppliers and pharmacies.

Provider Action Needed

Impact to You

Effective January 1, 2005, Medicare will pay a supplying fee for immunosuppressive drugs, oral anti-cancer chemotherapeutic drugs, and oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen in accordance with Section 303(e) (2) of the Medicare Modernization Act (MMA). Medicare will provide a dispensing fee for inhalation drugs supplied through durable medical equipment in accordance with Section 305 of the MMA.

What You Need to Know

Please note the distinction between supply fee and dispensing fee: The supply fee is for immunosuppressives, oral anti-cancer drugs, and oral anti-emetic drugs. The dispensing fee is for inhalation drugs furnished through durable medical equipment only. Also note that Medicare will not pay separately for compounding drugs because Medicare considers that cost as covered in the dispensing fees. ***Both the drug and the dispensing fee or the supply fee must be billed on the same claim. If the dispensing fee or supply fee is billed alone on the claim, it will be denied.***

What You Need to Do

This affects pharmacies and suppliers who submit claims to a Medicare Durable Medical Equipment Regional Carrier (DMERC). To ensure accurate claims processing, review the information included here and stay current with instructions for Medicare dispensing/supply fees.

Background

Section 303(e) (2) and Section 305 of the MMA provide for:

- Supplying fees for immunosuppressive drugs, oral anti-cancer chemotherapeutic drugs, and oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen; and
- Dispensing fees for inhalation drugs supplied through durable medical equipment.

The following table shows the codes to use in billing a DMERC and the payments that will be made by Medicare:

Code	Fee	Comments
G0370	$24	• G0370 applies to pharmacy supply fee for oral anti-cancer, oral anti-emetic, or immunosuppressive drug(s). • Effective January 1, 2005, Medicare will pay a supplying fee of $24 to a pharmacy *for each supplied prescription* of immunosuppressive drugs, oral anti-cancer drugs, and oral anti-emetic drugs.
G0369	$50	• G0369 applies to pharmacy supply fee for initial immunosuppressive drug(s) first month following transplant. • Effective January 1, 2005, Medicare will pay a supplying fee of $50 to a pharmacy *for the initial supplied prescription of immunosuppressive drugs to the patient during the first month following the transplant*. • This is a one-time payment per beneficiary, per transplant.
G0371	$57	• G0371 applies to pharmacy dispensing fee for inhalation drug(s), per 30 days. • Effective January 1, 2005, Medicare will pay a dispensing fee of $57 to a pharmacy *for a 30-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time*. • Only one dispensing fee payment will be made for the 30-day supply. • Please note that Medicare includes the cost of compounding drugs in the dispensing fees.
G0374	$80	• G0374 applies to pharmacy dispensing fee for inhalation drug(s), per 90 days. • Effective January 1, 2005, Medicare will pay a dispensing fee of $80 to a pharmacy *for each dispensed 90-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time*. • Only one dispensing fee payment will be made for the 90-day supply. • Please note Medicare includes the cost of compounding drugs in the dispensing fees.

Additional Information

Beneficiaries are required to pay the normal co-pay and deductible on both the drug and the supply/dispensing fee. Also, remember that, based on the code descriptions, a supply fee and a dispensing fee is not appropriate for one drug, because the supply fee is for immunosuppressives, oral anti-cancer, and oral anti-emetic drugs, whereas the dispensing fee is for inhalation drugs only. Also, remember that both the drug and the dispensing fee or supply fee must be billed on the same claim. If the dispensing fee or supply fee is billed alone, it will be denied.

When billing using the National Council for Prescription Drug Programs (NCPDP) format, the dispensing fee for supply fee (not the code) must appear on the same line as the drug. More specifically, providers should place the $24 (G0370) supplying fee amount, the $57 (G0371) dispensing fee amount, or the $80 (G0374) dispensing fee amount in the Dispensing Fee Submitted field (field 412DC) on the pricing segment of the NCPDP claim. For the $50 fee

(G0369), providers should place $24 of the fee in the field 412DC and the remaining $26 in the Incentive Amount Submitted field (Field 438-E3). When billing a dispensing fee with a drug on the NCPDP claim, providers should bill only one drug per claim.

The official instruction issued to your DMERC regarding this change can be found at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

On the above page, scroll down the CR NUM column on the right to find the link for CR 3620. Click on the link to open and view the file for the CR. The online document also includes the revisions to Medicare's Claims Processing Manual resulting from this change. If you have questions regarding this issue, you may contact your DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Mandatory Assignment for MMA Section 630 Claims

Medlearn Matters Number: MM3587
Related Change Request (CR) #: 3587
Related CR Release Date: January 14, 2005
Related CR Transmittal #: 430
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

The following information affects Indian Health Services (IHS), tribe, and tribal organization (non-hospital or non-hospital-based) facilities billing for those Part B drugs that are under the jurisdiction of Durable Medical Equipment Regional Carriers (DMERCs).

Provider Action Needed

This article is chiefly for informational purposes. It explains that if the IHS or an Indian tribe or tribal organization facility (hospital-based or non-hospital-based) submits an unassigned claim for a Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Section 630 item or service with a date of service on or after July 1, 2005, the DMERC must process the claim as though the IHS or the Indian tribe or tribal organization facility had accepted assignment of the claim.

Background

MMA Section 630 was implemented on January 3, 2005, according to CR 3288 (Transmittal R241CP). This instruction provides that claims submitted by the IHS or by an Indian tribe or tribal organization facility (hospital-based or non-hospital-based) to the DMERCs for the items and services listed below must be processed on an assigned basis. These items and services include the following:

- Durable medical equipment
- Prosthetics and orthotics
- Surgical dressings, splints, and casts
- Drugs (DMERC only)
- Clinical laboratory services
- Ambulance services

The process for submitting claims for Part B drugs furnished by the IHS or by Indian tribe or tribal organization facilities (hospital-based or non-hospital-based) was previously implemented under BIPA 432. MMA Section 630 has not changed the requirements for Trailblazers to process claims for Part B drugs in accordance with the Medicare Claims Processing Manual, Pub. 100-4, Chapter 19, Section 70.1. (This manual can be found at: ***www.cms.hhs.gov/manuals/104_claims/clm104index.asp***.) MMA Section 630 merely allows the IHS and Indian tribe and tribal organization facilities to submit claims to the DMERCs for those drugs for which the DMERCs have jurisdiction. This clarification also instructs the DMERCs to process such claims as assigned claims, even if the claim was submitted as unassigned.

Implementation

The implementation date for this instruction is July 5, 2005.

Additional Information

The official instruction issued to your DMERC regarding this change may be found at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

From that Web page, look for CR 3587 in the CR NUM column on the right and click on the file for that CR. If you have any questions, please contact your DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Fee Schedule Update for 2005 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Medlearn Matters Number: MM3574
Related Change Request (CR) #: 3574
Related CR Release Date: November 19, 2004
Related CR Transmittal #: 369
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects physicians, providers, and suppliers.

Provider Action Needed

This instruction provides specific information regarding the 2005 annual update for the DMEPOS fee schedule.

Background

The DMEPOS fee schedules are updated on an annual basis in accordance with the statute and regulations, as described in the Medicare Claims Processing Manual (Pub 100-04, Section 60, Chapter 23). This notification provides details regarding the 2005 annual update for the DMEPOS fee schedule.

The Social Security Act (SSA) (Sections 1834(a), (h), and (i)) requires payment on a fee schedule basis for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. In addition, the Code of Federal Regulations (42 CFR 414.102) requires payment on a fee schedule basis for Parenteral and Enteral Nutrition (PEN).

The 2005 DMEPOS fee schedule update factors for items furnished from January 1, 2005, through December 31, 2005, are as follows:

- DME other than items classified as class III devices by the Food and Drug Administration (FDA) – 0 percent
- DME classified as class III devices by the FDA – 3.3 percent
- Prosthetic devices, prosthetics, and orthotics – 0 percent
- PEN – 3.3 percent
- Surgical dressings – 0 percent

Please refer to the table below for comments and notes on several Healthcare Common Procedure Coding System (HCPCS) codes. The descriptions for the items falling under the HCPCS codes listed in the table can be obtained from the HCPCS file at ***www.cms.hhs.gov/medicare/hcpcs/default.asp***.

Healthcare Common Procedure Coding System Codes

HCPCS Codes	Notes
A4253, A4259, E0260, E0277, E0424, E0431, E0434, E0439, E0570, E1390, E1391, K0001, and K0011	These codes are affected by the provision in Section 302 (c)(2) of the Medicare Prescription Drug, Improve-ment, and Moder-nization Act of 2003 (MMA) requiring reductions for certain DME equal to the percentage difference between 2002 Medicare fee schedule amounts and the median 2002 price paid under Federal Employee Health Benefit (FEHB) plans surveyed by the Office of the Inspector General. The reduc-tions take effect January 1, 2005, and will be implemented as part of this annual update to the DMEPOS fee schedules.
A5500 (extra-depth shoe), A5501 (custom-molded shoe), K0628 (direct-formed insert), and K0629 (custom-molded insert)	Section 627 of the MMA requires the calculation and implementation of fee schedule amounts for therapeutic shoes and inserts effective January 1, 2005. Fee schedules for these HCPCS codes have been calculated by CMS using the methodology contained in Section 1834(h) of the Social Security Act for prosthetic devices, prosthetics, and orthotics. These fee schedule amounts will be implemented as part of this annual update to the DMEPOS fee schedules.
A5503 thru A5507 (shoe modification codes), and K0628 or K0629 (inserts)	In accordance with Section 1833(o)(2)(C) of the Social Security Act, the payment amounts established for shoe modification codes (A5503 thru A5507) must be established in a way that prevents a net increase in expenditures when substituting these items for inserts (codes K0628 or K0629). Therefore, the 2005 fee schedule amounts for codes A5503 thru A5507 have been calculated based on the weighted average of the fee schedule amounts for insert codes K0628 and K0629. The fees for K0628 and K0629 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2006 and each subsequent year, the weighted average insert fee used to establish the fee schedule amounts for the shoe modification codes will be based on an updated weighted average (i.e., using more current allowed service data for each insert code).
E0675	Code E0675 was added to the HCPCS effective January 1, 2004. The fee schedule for code E0675 was calculated using retail prices for two products; however, the fee schedule is being revised effective January 1, 2005, to remove pricing for one product that was not yet an established product in the market at the time the code was added.
E1010	The description for code E1010 for "wheelchair accessory, addition to power seating system, including leg rest, …each" is changed effective January 1, 2005, to show "wheelchair accessory, addition to power seating system,……., including leg rest, pair" and the fee schedule for E1010 is revised to reflect this change. Suppliers should bill single leg rest power elevation systems under code K0108.

HCPCS Codes	Notes
E2320 thru E2330, and Modifier KC	Codes E2320 thru E2330 for special power wheelchair interfaces were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated based on pricing for the differential cost of furnishing these special interfaces over a standard interface that is paid for as part of the payment for the wheelchair (e.g., K0011). However, when these items are furnished to replace existing interfaces on wheelchairs that have been in use by the patient for a period of time due to a change in the patient's medical condition or in cases where the existing interface is irreparably damaged or has exceeded its reasonable useful lifetime, the fee schedule payment should reflect payment for the full cost of the replacement special interface. Modifier KC is being added to the HCPCS effective January 1, 2005, to identify replacement of special power wheelchair interfaces in these cases. Fee schedule amounts for replacement of special power wheelchair interfaces will be established effective January 1, 2005, for use in paying claims for use codes E2320 thru E2330 billed with the KC modifier.
E2340 thru E2343, and K0108	Codes E2340 thru E2343 for nonstandard power wheelchair seat frame width and depth were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated using retail prices for some products for nonstandard seat dimensions (i.e., captain's chairs that sit on top of power wheelchair bases) as opposed to nonstandard seat frame dimensions. The base fee schedule amounts for codes E2340 thru E2343 will be adjusted to remove these products from the base fee calculations. Suppliers of nonstandard seat dimensions should bill HCPCS K0108 instead of codes E2340 thru E2343.
K0646, K0648, and L0565	The fee schedule amounts for codes K0646 and K0648 are being revised effective January 1, 2005, by crosswalking the fee schedule amounts for previous code L0565 to both code K0646 and K0648. As a result of a court settlement, previously paid claims for K0646 and K0648 that were submitted between July 6, 2004, and January 1, 2005, shall be adjusted if such claims are resubmitted by suppliers on or after January 1, 2005, and on or before 18 months after the date the claim was originally submitted.
E0617, E0691 thru E0694, K0606 thru K0609, and Modifier KF	A one-time notification (Transmittal 35, Change Request 3020) was issued on December 24, 2003, and listed HCPCS codes for categories of DME items identified by the FDA as class III devices. As indicated above, the fee schedule amounts for class III DME will be increased by 3.3 percent effective January 1, 2005, whereas the fee schedule amounts for items that are not classified as class III devices by the FDA will not be increased on January 1, 2005. Transmittal 35 indicated that HCPCS codes E0617, E0691 thru E0694, and K0606 thru K0609 represented codes for categories of DME items identified by the FDA as class III devices. However, some products billed under these codes are not class III devices. Therefore, effective January 1, 2005, separate fee schedules will be provided in the DMEPOS fee schedule file: one for class III products within these codes that must be billed with HCPCS modifier KF and one for products within these codes that are not class III devices that may not be billed with HCPCS modifier KF.
A7040, A7041, L8615 thru L8618, and L8620 thru L8622	Codes A7040, A7041, L8615 thru L8618, and L8620 thru L8622 describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2005. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. CMS will be calculating the fee schedule amounts for these items using the standard gap-filling process. The description for these codes can be obtained from the 2005 HCPCS file as soon as it is available at: ***www.cms.hhs.gov/medicare/hcpcs/default.asp***
A4324 thru A4325, A4347, A4609 thru A4610, B4151, B4156, E0176 thru E0179, E0192, E0454, E0962 thru E0965, E1012 thru E1013, K0023 thru K0024, K0059 thru K0061, K0081, K0114 thru K0116, K0627, L0476, L0478, L0500, L0510, L0515, L0520, L0530, L0540, L0550, L0560 thru L0561, L0565*, L0600, L0610, L0620, L2435, L5674 thru L5675, L5846 thru L5847, L5989, and L8490	These codes are being deleted from the HCPCS effective January 1, 2005, and are therefore being removed from the DMEPOS and PEN fee schedule files. *As indicated above, the fee schedule amounts for code L0565 are being crosswalked to codes K0646 and K0648.

Additional Information

The official instruction issued to your carrier, intermediary, or DMERC regarding this change can be found at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3574. Click on the link to open and view the file for the CR. If you have questions regarding this issue, you may also contact your carrier, fiscal intermediary, or DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Annual Update of HCPCS Codes Used for Home Health (HH) Consolidated Billing Enforcement

Medlearn Matters Number: MM3525
Related Change Request (CR) #: 3525
Related CR Release Date: October 29, 2004
Related CR Transmittal #: 340
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects physicians, providers, home health agencies (HHAs), and suppliers.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2005. Affected providers should be aware of these changes.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the HHA. As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA).

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Additional Information

This notification provides the annual HH consolidated billing update effective January 1, 2005. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2005:

Code	Description of Code	Type Change	Replacement Code or Code Being Replaced
Non-Routine Supplies			
A4347	Male external catheter	Delete	Replacement code: A4349
A4324	Male ext cath w/adh coating	Delete	Replacement code: A4349
A4325	Male ext cath w/adh strip	Delete	Replacement code: A4349
A4349	Male ext catheter, with or without adhesive, disposable, each	Add	Replaces codes: A4347, A4324, A4325
A7040	One way chest drain valve	Add	
A7041	Water seal drainage container and tubing for use with implanted chest tube	Add	
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	Add	
A7527	Tracheostomy/laryngectomy tube plug/stop, each	Add	
Therapies			
97601	Wound care selective	Delete	Replacement codes: 97597, 97598
97597	Removal of devitalized tissue from wound(s), selective debridement; surface area less than or equal to 20 square centimeters	Add	Replaces code: 97601
97598	Removal of devitalized tissue from wound(s), selective debridement; total wound(s) surface area greater than 20 square centimeters	Add	Replaces code: 97601
97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection); total wound(s) surface area less than or equal to 50 square centimeters	Add	
97606	Negative pressure wound therapy (e.g., vacuum assisted drainage collection); total wound(s) surface area greater than 50 square centimeters	Add	

The last update to the HH consolidated billing was issued under Transmittal 226, CR 3350. This CR can be found at:
www.cms.hhs.gov/manuals/pm_trans/R226CP.pdf

The official instruction issued to your carrier/ intermediary (including Durable Medical Equipment Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs)) 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 3525 in the CR NUM column on the right, and click on the file for that CR. If you have any questions regarding this issue, please contact your carrier/intermediary at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

2005 Annual Update for Skilled Nursing Facility (SNF) Consolidated Billing for the Common Working File (CWF) and Medicare Carriers

Medlearn Matters Number: MM3535
Related Change Request (CR) #: 3535
Related CR Release Date: October 22, 2005
Related CR Transmittal #: 328
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects Skilled Nursing Facilities (SNFs).

Provider Action Needed

Impact to You
The 2005 update for SNF Consolidated Billing (CB) is available. These codes are used in applying the SNF CB edits that only allow services that are excluded from CB to be separately paid by Medicare carriers.

What You Need to Know
These new code files are posted to the Centers for Medicare & Medicaid Services (CMS) Web site at:
www.cms.hhs.gov/medlearn/snfcode.asp

What You Need to Do
The edits for claims received for beneficiaries in both Part A SNF stays and covered and non-covered Part A SNF stays allow services that are excluded from consolidated billing to be separately paid by the carrier.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to:
www.cms.hhs.gov/manuals/pm_trans/R328CP.pdf

For additional information relating to this issue, please contact your carrier at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Correction to January 2005 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Medlearn Matters Number: MM3613
Related Change Request (CR) #: 3613
Related CR Release Date: December 30, 2004
Related CR Transmittal #: 421
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects Skilled Nursing Facility (SNF) and ambulance suppliers billing Medicare carriers or intermediaries for patients in an SNF stay.

Provider Action Needed

Impact to You
Transmittal 360 (Change Request (CR) 3542) of the Medicare Claims Processing Manual (published on November 5, 2004) was the 2005 Skilled Nursing Facility annual update. CR 3613 provides a correction to the annual SNF CB update for calendar year 2005 by adding one code under Major Category I.H. (Ambulance Services) that was inadvertently omitted, namely A0999 – unlisted ambulance service.

What You Need to Know
Healthcare Common Procedure Coding System (HCPCS) codes 53660, 95974, and G0168 had been

reported twice in Major Category I.F. – this duplication of codes has also been corrected.

What You Need to Do
To ensure accurate claims processing, please review the information included here and stay current with instructions for SNF CB.

Additional Information
The official instruction issued regarding this change can be found at:
www.cms.hhs.gov/manuals/pm_trans/R421CP.pdf

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

April Quarterly Update to 2005 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (SNF PPS). Change Request (CR) 3683 provides a list of the codes being added or removed from the annual update effective April 1, 2005. Quarterly updates now apply to both Fiscal Intermediaries (FIs) and Carriers/Durable Medical Equipment Regional Carriers (DMERCs).

For the annual notice on SNF CB each January, separate instructions are published for FIs and Carriers/DMERCs. The 2005 Annual Update for FIs can be found on the CMS Web site at:
www.cms.hhs.gov/manuals/pm_trans/R360CP.pdf.
Information on the 2005 annual update for Carriers can be found at: ***www.cms.hhs.gov/medlearn/snfcode.asp***

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. For more information, please refer to the Medlearn Matters article on the CMS Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3683.pdf

Skilled Nursing Facility (SNF) Consolidated Billing Service Furnished Under an "Arrangement" with an Outside Entity

Medlearn Matters Number: MM3592
Related Change Request (CR) #: 3592
Related CR Release Date: December 23, 2004
Related CR Transmittal #: 412
Effective Date: May 21, 2004
Implementation Date: January 24, 2005

The following information affects any physician, provider, or supplier who renders a Medicare-covered service subject to consolidated billing to an SNF resident.

Provider Action Needed
No provider action is necessary. This article is informational only and clarifies the instruction contained in Change Request (CR) 3248, issued on May 21, 2004. It explains that an "arrangement" between a Medicare Skilled Nursing Facility (SNF) and its supplier is validated not by the presence of specific supporting written documentation but rather by their actual compliance with the requirements governing such "arrangements." However, supporting written documentation delineating the "arranged-for" services for which the SNF assumes responsibility and the manner in which the SNF will pay the outside entity for those services can help the parties arrive at a mutual understanding on these points.

Background
Under the SNF consolidated billing provisions of the Social Security Act (the Act), the Medicare billing responsibility is placed with the SNF itself for most of its residents' services. (See Sections 1862(a)(18),

1866(a)(1)(H)(ii), and 1888(e)(2)(A)). The SNF must include on its Part A bill submission to its Medicare intermediary almost all of the services a resident receives during a covered stay, excluding those services which are not covered under the SNF's global prospective payment system (PPS) per diem payment for the particular stay.

These excluded services (e.g., those provided by physicians and certain other practitioners) continue to be separately billable to Part B directly to the Medicare carrier by those "outside entities" that actually provide the service. Also, Part B consolidated billing makes the SNF itself responsible for the submission of Part B bills for any *physical, occupational, or speech-language therapy services* received by a resident during a *non-covered* stay.

In addition, the SNF must provide any Part A or Part B service that is subject to SNF consolidated billing either directly with its own resources or through an outside entity (e.g., a supplier) under an "arrangement," as set forth in Section 1861(w) of the Act. If an outside entity provides a Medicare-covered service that is subject to SNF consolidated billing to an SNF resident during a covered stay, the outside entity must look to the SNF for payment (rather than billing their carrier under Part B). The reason is because under an arrangement, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the SNF in turn is responsible for making payment to outside entities if the service provided is subject to the SNF's global prospective payment system (PPS) per diem payment.

Problem Situations

Since the start of the SNF PPS, problematic situations have arisen when the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. These problems are usually connected with either of two scenarios, namely:

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

In this context, the term "supplier" can also include those practitioners who, in addition to performing their separately billable professional services, essentially act as a supplier by also furnishing other services that are subject to the consolidated billing requirement.

Documenting Arrangements

SNFs should document, in writing, arrangements with suppliers that render services on an ongoing basis (e.g., pharmacies, laboratories, and x-ray suppliers). Documentation of a valid arrangement, including mutually agreeable terms, should help to avoid confusion and friction between SNFs and their suppliers. Suppliers need to know which services fall under the consolidated billing provisions so they do not improperly bill Medicare carriers under Part B or other payers (like Medicaid and beneficiaries) directly for services.

It is also important that when ordering or providing services "under arrangement," the parties reach a mutual understanding of all the payment terms, e.g., how to submit an invoice, how payment rates are determined, and the "wait" time between billing and payment.

SNF's Responsibility

However, the absence of a valid arrangement (written or not) does not nullify the SNF's responsibility to pay suppliers for services "bundled" in the SNF PPS global per diem rate. The SNF must be considered the responsible party (even in cases where it did not specifically order the service) when beneficiaries in Medicare Part A stays receive medically necessary supplier services, because the SNF has already been paid under the SNF PPS. Examples of this obligation occur when:

- The physician performs additional diagnostic tests during a scheduled visit that had not been ordered by the SNF; or
- A family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

Establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties. However, occasional disagreements between the parties that result in non-payment of a supplier claim may occur. When

patterns of such denials are identified, there are potentially adverse consequences to SNFs. The reason is because all SNFs, under the terms of their Medicare provider agreement, must comply with program regulations. These regulations require a valid arrangement to be in place between the SNF and any outside entity providing resident services subject to consolidated billing. Moreover, in receiving a bundled per-diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment and financial responsibility for the service.

Under Section 1862(a)(18) of the Act, there is no valid "arrangement" if an SNF obtains services subject to consolidated billing from an outside supplier but refuses to pay the supplier for said services. This situation could result in the following consequences:

- The SNF is found in violation of the terms of its provider agreement; and/or
- Medicare does not cover the particular services at issue.

The SNF's provider agreement includes a section requiring a specific commitment to comply with the requirements of the consolidated billing provision (see Section 1866(a)(1)(H)(ii) of the Act and the regulations at 42 CFR 489.20(s)). Also Section 1866(g) of the 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.

Additional Guidance

In the absence of a valid "arrangement" between an SNF and its supplier, the problems which arise tend to fall into one of the following problem scenarios.

Problem Scenario 1

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 non-covered, the supplier inappropriately submits a separate Part B claim for the service and may also improperly bill other insurers and the resident. Then the supplier 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.

The Centers for Medicare & Medicaid Services (CMS) realizes that unintentional mistakes occasionally may occur when furnishing such information. However, the SNF is responsible for making a good faith effort to provide accurate information to its supplier and to pay the supplier once the error is pointed out. If in Scenario 1 above the SNF refuses to pay the supplier even after the accuracy of its initial information is called to its attention, the SNF would risk being in violation of its provider agreement by not complying with consolidated billing requirements. As stated previously, supporting written documentation for the disputed service would provide a basis for resolving the dispute and aid in ensuring compliance with the consolidated billing requirements.

By making sure that it sends accurate and timely information to its supplier regarding a resident's covered stay, the SNF can often prevent disputes such as those described in Scenario 1 from arising. The communication of accurate and timely resident information by the SNF to the supplier is especially important when a portion of an otherwise "bundled" service remains separately billable to Part B (e.g., the professional component representing a physician's interpretation of an otherwise "bundled" diagnostic test).

Problem Scenario 2

A resident 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. The SNF refuses to pay for the offsite services and the supplier bills the beneficiary/family member directly.

As in the previous scenario, the SNF remains responsible for any services included in the SNF

"bundle" of services subject to consolidated billing that are furnished to the resident by an outside entity, *even in the absence of a valid arrangement with the SNF*.

The SNF can take steps to prevent problems like this from occurring by making sure that the resident or his/her representative fully understands the applicable requirements. For example, under Section 1802 of the Act, Medicare law guarantees to a beneficiary the right to choose any qualified entity willing to provide services to him/her. By selecting a particular SNF, the beneficiary has in effect exercised this right of choice regarding the entire array of services for which the SNF is responsible under the consolidated billing requirement and agrees to use only those outside suppliers that the SNF selects or approves to provide services.

The staff of the SNF should explain these rights and requirements to the beneficiary and his/her family members or representative(s) during the admission process, periodically throughout each resident's stay, and upon the resident's temporarily leaving the facility.

The supplier in this scenario also retains responsibility for preventing problems from arising by understanding and complying with the consolidated billing requirements. Therefore, before providing beneficiary services, the supplier should determine whether that beneficiary currently receives any comprehensive Medicare benefits (e.g., SNF or home health) which could include the supplier's services. If the beneficiary is a resident of an SNF with which the supplier does not have a valid "arrangement," the supplier should consult with the SNF before actually furnishing any services which may be subject to the consolidated billing provision. Further, the supplier should know that the beneficiary cannot be charged for the bundled service in accordance with the regulations at 42 CFR 489.21(h).

Additional Information

The Medicare Claims Processing Manual has been revised to include language reflecting this clarification. That revision is attached to the official instruction issued to your carrier/intermediary regarding this change. The official instruction may be found at:
www.cms.hhs.gov/manuals/pm_trans/R412CP.pdf

Also 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

Skilled Nursing Facility Consolidated Billing

The Centers for Medicare & Medicaid Services (CMS) revised Medlearn Matters Special Edition article SE0431 on January 20, 2005, to include clarifying language (see below), but no substantive changes were made. The original article was published on page 7 of the December 2004 *DMERC Medicare News*.

Clarification: The Skilled Nursing Facility (SNF) Consolidated Billing (CB) requirement make the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These included services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare Durable Medical Equipment Regional Carrier (DMERC).)

For the complete text, refer to the revised article on CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp)

The Centers for Medicare & Medicaid Services (CMS) revised Medlearn Matters Special Edition article SE0434 on January 25, 2005, to include clarifying

language (see below), but no substantive changes were made. The original article was published on page 10 of the December 2004 *DMERC Medicare News*.

Clarification: The Skilled Nursing Facility (SNF) Consolidated Billing (CB) requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These excluded services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of services (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare Durable Medical Equipment Regional Carrier (DMERC).)

For the complete text, refer to the revised article on CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0434.pdf

CWF Editing for Method Selection on Durable Medical Equipment Regional Carrier (DMERC) Claims for Epoetin Alfa (EPO) and Aranesp

Medlearn Matters Number: MM3547
Related Change Request (CR) #: 3547
Related CR Release Date: January 21, 2005
Related CR Transmittal #: 447
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

The following information affects Durable Medical Equipment (DME) suppliers billing DMERCs for EPO and Aranesp.

Provider Action Needed

Impact to You
Please note that Medicare DMERCs will only pay claims for *Epoetin Alfa* (EPO) and *Darbepoetin Alfa* (Aranesp) for Method II home dialysis (ESRD) patients.

What You Need to Know
Edits will be added to the Medicare systems to assure that the DMERCs pay claims for EPO and Aranesp only for Method II ESRD beneficiaries.

What You Need to Do
Claims will be denied for Aranesp and EPO where the beneficiary is not a Method II home dialysis patient. Such denials will be noted by a message on the remittance advice (ANSI message 7011) which will state: "Claim not covered by this payer contractor. You must send the claims to the correct payer contractor."

Background

When requirements for a patient care plan and patient selection (per the Medicare Benefit Policy Manual, Chapter 11), are met - Medicare will cover EPO or Aranesp used in the home for dialysis patients.

When EPO or Aranesp is prescribed for a home patient, it may be:

- Administered in a facility, e.g., the one shown on the Form CMS-382 (ESRD Beneficiary Method Selection Form), or
- Furnished by a facility or Method II supplier for self-administration to a home patient determined to be competent to administer this drug.

For EPO or Aranesp furnished for self-administration to competent Method I and Method II home patients the following applies:

- The renal facility bills its Fiscal Intermediary, and
- The Method II supplier bills its DMERC.

A Method II beneficiary is one who has chosen home dialysis and has chosen via Form CMS-382 to deal with a supplier of home dialysis equipment and supplies.

No additional payment is made for training a prospective self-administering patient or retraining an existing home patient to self-administer EPO or Aranesp.

Method II patients who self-administer EPO or Aranesp will only be able to obtain it from their Method II supplier, or from a Medicare-certified ESRD facility.

In this case, the DMERC will pay at the same rate that

applies to facilities. Program payment cannot be made for EPO or Aransep furnished by a physician to a patient for self-administration.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 60 (Separately Billable ESRD Items and Services), Subsections 60.4.4 and 60.7.4 have been revised to reflect this change. The revised part of the manual is attached to the official instruction issued to your DMERC regarding this change. This instruction may be found at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR 3547 in the CR NUM column on the right, and click on the file for that CR. For additional information relating to this issue, please refer to your DMERC. Please find the toll-free phone number for your DMERC at:
www.cms.hhs.gov/medlearn/tollnums.asp

Replacement of Change Request (CR) 3373 - Payment to Providers/Suppliers Qualified to Bill Medicare for Prosthetics and Certain Custom-Fabricated Orthotics

Medlearn Matters Number: MM3607
Related Change Request (CR) #: 3607
Related CR Release Date: January 21, 2005
Related CR Transmittal #: 445
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

The following information affects physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel, and prosthetics personnel who provide or supply Prosthetics and Orthotics (P&O) billing Medicare Durable Medical Equipment Regional Carriers (DMERCs).

Provider Action Needed

Impact to You

If the National Supplier Clearinghouse (NSC) does not have your correct specialty code on file, your claim for prosthetics and certain custom-fabricated orthotics will be rejected. Please be sure your correct specialty codes are on file with the NSC.

What You Need to Know

Medicare will only reimburse for prosthetics and certain custom-fabricated orthotics (P&O) when furnished by physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel, and prosthetics personnel as recognized by the appropriate specialty code.

CR 3607 puts new edits in the DMERC claims processing system to look for specialty codes 51, 52, 53, 55, 56, 57, 65, 67, and all Physician Specialty Codes listed in Manual Pub. 100-04, Chapter 26, Section 10.8.2, in order to assure that only those who specify P&O on their Enrollment Application Forms (Form CMS-855S), are reimbursed for P&O supplies.

What You Need to Do

Make sure that your billing staffs have provided your specialty codes to the NSC.

Background

Section 1834(h) of the Social Security Act (the Act) provides for payment of "orthotics and prosthetics," which are described in Section 1861(s)(8) and (9) of the Act and in Medicare regulations (42 CFR § 414.202). DMERCs have historically processed prosthetic and orthotic claims from all enrolled and approved providers/suppliers without regard to the specialty identified and services to be provided on the Enrollment Application Form (Form CMS-855S).

However, Section 1834(h)(1)(F) of the Act specifies that no payment is to be made for custom-fabricated orthotics and prosthetics unless furnished by a qualified practitioner or a qualified supplier. This instruction puts new edits in the DMERC claims processing system to look for particular specialty codes to assure that those providers specifying P&O on their Enrollment Application Forms are the only entities billing Medicare for P&O supplies.

To explain, the Centers for Medicare & Medicaid Services (CMS) has deemed that certain specialties (who are licensed or certified by the state, when

applicable) are qualified to furnish prosthetics and certain custom-fabricated orthotics, and may bill for Medicare services when state law permits them to furnish a prosthetic or orthotic item. These qualified specialties (and their specialty codes) are:

- Medical Supply Company with Orthotics Personnel – Specialty Code 51;
- Medical Supply Company with Prosthetics Personnel – Specialty Code 52;
- Medical Supply Company with Orthotics and Prosthetics Personnel – Specialty Code 53;
- Orthotics Personnel – Specialty Code 55;
- Prosthetics Personnel – Specialty Code 56;
- Orthotics Personnel, Prosthetics Personnel, and Pedorthists – Specialty Code 57;
- Physical Therapist – Specialty Code 65;
- Occupational Therapist – Specialty Code 67; and
- All Physician Specialty Codes listed in Manual Pub. 100-04, Chapter 26, Section 10.8.2.

Please remember that the National Supplier Clearinghouse (NSC) is responsible for maintaining a central data repository for information regarding suppliers. Therefore, if you want to bill to Medicare for P&O, you should check with the NSC to ensure that your correct specialty code is on file, and if you need to update your file with the correct code, you must submit to the NSC a "Change of Information" on the CMS-855S form. In turn, the NSC will transmit this information to your DMERC.

You should also be aware that the effective date for the new or revised specialty code for P&O claims will be the date the NSC issues the specialty code. The new or revised specialty code will not be applied retroactively.

Additional Information

You can find more information about payment to providers/suppliers qualified to bill Medicare for prosthetics and certain custom-fabricated orthotics, including the 2004 list of Healthcare Common Procedure Coding System (HCPCS) Codes for customized orthotics and prosthetics by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

From that Web page, look for CR 3607 in the CR NUM column on the right, and click on the file for that CR. You might also want to look at the online Manual Pub. 100-04, Chapter 20, Section 130.1 (Provider Billing for Prosthetics and Orthotic Services). You can find this manual at: ***www.cms.hhs.gov/manuals/104_claims/clm104c20.pdf***

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

Unprocessable Unassigned Form CMS-1500 Claims

Medlearn Matters Number: MM3500
Related Change Request (CR) #: 3500
Related CR Release Date: January 21, 2005
Related CR Transmittal #: 443
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

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

Provider Action Needed

No provider action is needed. This instruction makes necessary changes to assure consistency in the handling of Medicare Part B claims and that Health Insurance Portability and Accountability Act of 1996 (HIPAA) non-compliant data is not transmitted to Coordination of Benefits (COB) trading partners.

Provider Impact

Formerly, unassigned claims were denied with appeal rights. However, this instruction notifies physicians, providers, and suppliers that unassigned Centers for Medicare & Medicaid Services (CMS) Form 1500 claims and electronic interface equivalents that are incomplete or contain invalid information will be returned as unprocessable to the submitters for correction or resubmission. It is important to note that as an unprocessable, when the claim is returned, there are no appeal rights.

When the claims are corrected and then processed, electronic crossover claims can be sent to COB trading partners that are HIPAA-compliant, and the COB secondary payer claims can be processed for Medicare beneficiaries.

Background

The Medicare Claims Processing Manual (Pub. 100-04) provides instructions for handling Medicare claims, including Part B Form CMS-1500 claims that have incomplete or invalid information. Such claims are to be returned without appeal rights. See Pub. 100-04, Chapter 1 (General Billing Requirements), Section 80.3.1 (Incomplete or Invalid Claims Processing Terminology) at:
www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf

Currently, the instructions for Form CMS-1500 claims are:

- Specified to apply only to assigned Part B claims, and
- Silent as to unassigned CMS-1500 claims.

As a result, many Part B carriers and DMERCs have been denying unassigned CMS-1500 claims with appeal rights and not returning these claims as unprocessable without appeal rights. In addition, when denying these claims, the carriers/DMERCs have been sending to COB secondary payers electronic crossover claims containing HIPAA non-compliant claims data (such as diagnosis codes and procedure codes that are not part of the standard code sets).

Under HIPAA rules, COB trading partners are not required to process claims that are not HIPAA-compliant, and in claims with multiple service lines, the entire claim might be rejected. The inclusion of HIPAA non-compliant data has resulted in some COB trading partners refusing to process such crossover claims for Medicare beneficiaries.

Implementation

The implementation date for this instruction is July 5, 2005.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 1 has been revised and is included as an attachment to the official instruction released to your carrier. You may view that instruction at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR 3500 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Interest Payment on Clean Claims Not Paid Timely

Medlearn Matters Number: MM3557
Related Change Request (CR) #: 3557
Related CR Release Date: December 23, 2004
Related CR Transmittal #: 416
Effective Date: January 25, 2005
Implementation Date: January 25, 2005

The following information affects physicians, providers, and suppliers billing Medicare carriers and intermediaries, including durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Physicians, providers, and suppliers should note that this article clarifies information relating to the calculation of interest due on claims not paid in a timely manner by Medicare.

Background

The Medicare Claims Processing Manual (Pub. 100-04, Chapter 1, Section 80.2.2) provides instructions for assessing and calculating interest due on non-periodic interim payment (PIP) claims not paid in a timely manner by fiscal intermediaries (FIs) and carriers. It states the following:

- Interest is required to be paid for clean claims not paid within 30 days after the day of receipt of a claim.
- Interest accrues until and including the day of late payment.

Related Change Request (CR) 3557 corrects Chapter 1, Section 80.2.2 of the Medicare Claims Processing Manual. For your convenience, the following revised language from Section 80.2.2 is provided with revisions (bold and italicized):
"Interest must be paid on clean claims if payment is not made within the applicable number of calendar days ***(i.e., 30 days)*** after the date of receipt as described above. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993. Interest is not paid on:

- Claims requiring external investigation or development by the provider's FI ***or carrier***;

- Claims on which no payment is due;
- Full denials;
- Claims for which the provider is receiving PIP; or
- Home Health Prospective Payment System (HH PPS) Requests for Anticipated Payment (RAPs)."

Interest is paid on a per bill basis at the time of payment. Interest is paid at the rate used for §3902(a) of Title 3l, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. For the correct rate, providers may access the Treasury Department Web page, ***www.publicdebt.treas.gov/opd/opdprmt2.htm***, for the correct rate. Also, the carrier or FI notifies the provider of any changes to this rate.

Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment. Note that the example below is for one 6-month period in which the interest rate was 5.625 percent.

Milestones	Clean Paper Claim (in calendar days)	Clean Electronic Claim (in calendar days)
Date Received	November 1, 2001	November 1, 2001
Payment Due	***December 1, 2001***	***December 1, 2001***
Payment Made	December 4, 2001	December 4, 2001
Interest Begins	December 2, 2001	December 2, 2001
Days for Which Interest Is Due	***3***	***3***
Amount of Payment	$100	$100
Interest Rate	5.625%	5.625%

See §80.2.1.1 for the definition of electronic media claims (EMC) and paper claims.

The following formula is used:

- For the clean paper claim: $100 x .05625 x ***3*** divided by 365 = ***$0.0462***, or ***$0.05*** when rounded to the nearest penny.
- For the clean electronic claim: $100 x .05625 x ***3*** divided by 365 = ***$0.0462***, or ***$0.05*** when rounded to the nearest penny.

When interest payments are applicable, the FI or carrier reports the amount of interest on each claim on the remittance record to the provider.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found by going to:
www.cms.hhs.gov/manuals/pm_trans/R416CP.pdf

Implementation Date

The implementation date for this instruction is January 25, 2005.

Unsolicited/Voluntary Refunds

Medlearn Matters Number: MM3274
Related Change Request (CR) #: 3274
Related CR Release Date: July 30, 2004
Related CR Transmittal #: 50
Effective Date: October 1, 2004/January 1, 2005
Implementation Date: October 1, 2004/January 3, 2005

The following information affects all Medicare providers.

Provider Action Needed

Providers need to be aware that 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 any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries.

But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

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

The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative

Medlearn Matters Number: SE0469
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects physicians, providers, and suppliers, especially in California, Florida, and New York.

Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of Recovery Audit Contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose. As the states with the largest Medicare expenditure amounts, California, Florida, and New York have been selected for pilot RACs that will begin during the first part of 2005 and last for three years. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the Medicare Affiliated Contractors (MACs), which include carriers, fiscal intermediaries (FIs), and Durable Medical Equipment Regional Carriers (DMERCs).

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in 1) identifying underpayments and overpayments, and 2) recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

A small percentage of claims (< 5 percent) are examined during medical review of claims performed by the MACs, and in annual studies of the Medicare program, claims payment error rates of between 6 percent and 10 percent have been identified. It is further estimated that in the last two fiscal years, billions of dollars have been inappropriately paid out by Medicare. There is growing concern that the Medicare Trust Funds may not be adequately protected against erroneous payment through current administrative procedures.

This pilot program is designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the MACs. To accomplish this, the following is planned:

- There will be RACs for both Medicare Secondary Payer (MSP) and non-MSP claims and activity.
- Compensation for RACs will be provided through retention of a percentage of the overpayment recoveries.

The following provides additional details about the RACs pilot program:

- Claims reviewed by RACs will have been submitted to the carriers/intermediaries at least a year before to ensure that the ordinary processing will have been completed.
- RACs will 1) perform data analysis to identify areas of investigation, and 2) request claims history information from the carriers/intermediaries.
- Non-MSP RACs will identify and recover claims overpayments only. They will not be permitted to establish cost report overpayments.
- RACs will apply national coverage policies and Local Coverage Determinations (LCDs) that have been approved by the MACs.
- The collection policies to be applied by this pilot will be the same as those currently in effect for the carriers/intermediaries, including assessment of interest

on the portion of any debt that is unpaid 30 days after issuance of the demand letter.

- No new policy will be applied. In addition:
  - Providers will be permitted to appeal any negative determinations to their MAC; and
  - If underpayments are determined, the information will be forwarded to the MACs for processing and payment.

The Centers for Medicare & Medicaid Services (CMS) selected the following three states with the largest Medicare benefit payment amounts as the pilot states for the Recovery Audit Contracts:

- California
- Florida
- New York

CMS released a Request for Proposal (RFP) to interested qualified bidders and expects the contractor selections to be made in the beginning of 2005. It is expected that RACs will start work in May of 2005, and the duration of the pilot contracts will be three years.

Each of the three pilot states will have 1) one contractor for non-MSP claims overpayment recovery and 2) another (or possibly the same) contractor for MSP recoveries. To avoid a conflict of interest, current Medicare contractors are not eligible to bid on these contracts.

A complete evaluation of the pilot program will be made before extending it in the three designated states or to additional states.

Additional Information

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

Find out more about the Medicare Prescription Drug and Modernization Act of 2003 (MMA) at the following CMS Web site:
www.cms.hhs.gov/medicarereform/

In addition, Section 306 was taken from the MMA and is provided below:

House Rpt.108-181 - PROVIDING FOR CONSIDERATION OF H.R. 1, THE MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL - The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program for services for which payment is made under part A or B of title XVIII of the Social Security Act. Under the project -
  (1) Payment may be made to such a contractor on a contingent basis;
  (2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and
  (3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION -
  (1) SCOPE - The project shall cover at least 2 States that are among the States with -
    (A) The highest per capita utilization rates of Medicare services, and
    (B) At least 3 contractors.
  (2) DURATION - The project shall last for not longer than 3 years.

(c) WAIVER - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS -
  (1) IN GENERAL - The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.
  (2) INELIGIBILITY OF CERTAIN CONTRACTORS - The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY - In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD - A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT - The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

Durable Medical Equipment Carrier – Revision to CR 2631 for Durable Medical Equipment Carriers Only

Medlearn Matters Number: MM3261
Related Change Request (CR) #: 3261
Related CR Release Date: November 3, 2004 **Revised**
Related CR Transmittal #: 353
Effective Date: April 1, 2005
Implementation Date: April 4, 2005
Note: This article was revised on November 12, 2004, to delete language referring to Optical Character Reader and Keyshop claims. That language only applied to the durable medical equipment regional carriers.

The following information affects durable medical equipment suppliers.

Provider Action Needed

Impact to You

Effective April 1, 2005, instead of the 2010AA Billing Provider loop to document place of service (POS) in your Durable Medical Equipment Carrier (DMERC) claims, you must use the 2420C Service Facility loop (line level) or 2310D (claim level). If you use the 2010AA loop and not one of these latter two loops, your claims will be returned as unprocessable when the place of service is other than home.

What You Need to Know

In your DMERC claims, if the place of service reported in either the 2300.CLM05 or the 2400.SV105 is anything other than Home - 12 (or Centers for Medicare & Medicaid Services (CMS) equivalent POS codes of 4-homeless shelter, 13-assisted living, and 14-group home), the Medicare claims processing system will only use the 2420C and 2310D loops to make the appropriate place of service determination. The Medicare System will not use the 2010AA loop to determine the valid place of service in these instances.

What You Need to Do

Make sure that your billing staff knows that, on your DMERC claims, they must use the 2420C and 2310D loops (and not the 2010AA Billing Provider loop) to document the place of service when that place is other than the home of the beneficiary.

Background

This article addresses Change Request (CR) 3261 that revises an earlier one (CR 2631). CR 2631 (Transmittal 1813B3, dated August 1, 2003) implemented procedures to follow when the POS on your claim is other than home (Code – 12 or equivalent as mentioned earlier).

It required that, on version 4010/4010A of the ASC X12N 837 electronic claim format, you provide the name, address, and zip code of the location where the service was performed, for all claims received on or after April 1, 2004. More specifically, it required that Billing Provider loop 2010AA always be completed, and was to be heavily relied on to serve as the documentation of a valid place of service. The problem with this requirement in CR 2361 is that if the POS is not actually "home," the 2010AA loop billing may not be where the service was provided. It could actually be supplier information and not the place of service.

Although all claims must have a completed 2010AA Billing Provider loop, beginning April 1, 2004, this does not ensure that your claim has been properly submitted, because the Billing or Pay To Provider's location may not be where the services were rendered. Therefore, in

order to process claims correctly, the following change must be made for DMERC claims only:

- The Medicare system will not use the 2010AA loop to make the appropriate facility determination. It will only use the 2420C and 2310D loops to determine POS. Requirements for the required information for these two loops are not being changed with these instructions.
- The Medicare system will provide edits that require you to supply complete facility information at either the 2310D or the 2420C loops if the place of service reported in either the 2300.CLM05 or the 2400.SV105 is other than Home – 12 (or the equivalent POS codes as determined by CMS). If you don't, the claim will be returned to you with the appropriate remarks code as stated in CR 2631.

Note: The Medicare Standard System first looks to the line item/2420C and then looks to the claim item/2310D for POS information. Currently, it then looks to the Header Information at 2010AA.

Implementation Date

The implementation date for these changes will be April 4, 2005.

Additional Information

You can find CR 3261 by going to:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR 3261 in the CR NUM column on the right, and click on the file for that CR number. The revised pages of the online manual Pub 100-4, Chapter 1, Section 10 are attached to that CR. In addition you can find CR 2631 at:
www.cms.hhs.gov/manuals/pm_trans/R1813B3.pdf

Finally, 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

Guidance Regarding Elimination of Standard Paper Remittance (SPR) Advice Notices in the Old Format

Medlearn Matters Number: SE0451
Related Change Request (CR) #: N/A
Effective Date: N/A **Revised**
Implementation Date: January 1, 2005, for providers billing carriers; April 4, 2005, for providers billing fiscal intermediaries
Note: This article was revised on December 7, 2004, to revise the implementation date for providers billing fiscal intermediaries (FIs) and clarifies expectations for carrier changes.

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) has issued a memorandum to all Medicare carriers and fiscal intermediaries (FIs), including Durable Medical Equipment Regional Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs) stating that, effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the Standard Paper Remittance (SPR) advice notices; no other format for SPRs will be used.

Background

CMS prohibits the inclusion of data in paper remittance advice notices that is not included in the Electronic Remittance Advice (ERA) transactions. The most recent version of the SPR advice and the ERA contain the same information in the comparable fields and data elements, including the same codes. The same flat file should be used to produce both the SPR and 835 version 4010A1 ERA.

Note: The effective date has been revised to April 4, 2005, for FIs.

Providers billing intermediaries are also advised that they may see new data elements in their SPRs, i.e.:

- An additional field for the new technology add-on payment;
- A "PRE PAY ADJ" (presumptive payment adjustment) field in the claim detail section; and
- A new field to report a provider-level adjustment used to balance an "out of balance" remittance on the SPR summary page.

Providers billing carriers should note that not all carriers and DMERCs will be able to create SPRs directly from an 835 flat file. In such cases, carriers and DMERCs may continue to follow current practices for SPR preparation, but they must ensure that each SPR issued contains the same data elements that would be

reported in the equivalent segments and data elements of an 835 version 4010A1 if produced for the same claims and provider. This applies to SPRs produced both for providers that have already transitioned to the 835 version 4010A1, and to those that received earlier versions of the 835 or the National Standard Format (NSF) ERA pending transition.

Also, providers billing carriers and DMERCs should know that carriers and DMERCs have been told that SPRs may not contain data, other than the contractor's name and address and some calculated totals (as permitted in the SPR format in Chapter 22 of the Medicare Claims Processing Manual), that is not reported in the ERA.

Additional Information

Refer to Chapter 22 of the Medicare Claims Processing Manual, Publication 100-4, which can be found online at: ***www.cms.hhs.gov/manuals/104_claims/clm104c22.pdf***

Additional information regarding the Fiscal Intermediary Part A 835 flat file, including a sample of the most recent SPR format, is available in CR 3344. You may view that CR at: ***www.cms.hhs.gov/manuals/pm_trans/R252CP.pdf***

If you have any questions regarding receipt of or conversion to ERAs, please contact your carrier/intermediary. If you bill an intermediary, their number may be found at: ***www.cms.hhs.gov/providers/edi/anum.asp***. If you bill a carrier, their number may be found at: ***www.cms.hhs.gov/providers/edi/bnum.asp***

Carrier and DMERC 835 Flat File Change and Replacement of Deactivated Reason Code A2

Medlearn Matters Number: MM3236
Related Change Request (CR) #: 3236
Related CR Release Date: July 30, 2004 **Revised**
Related CR Transmittal #: 103
Effective Date: January 1, 2005
Implementation Date: January 3, 2005
Note: This article was revised on December 6, 2004, to show that the deactivation of Reason Code A2 also applies to Medicare carriers.

The following information affects all providers who submit claims to Medicare carriers, including durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Impact to You

This one-time notification informs you of the Deactivation of Reason Code A2 for carriers and DMERCs.

What You Need to Know

Providers should be aware of the flat file change and the deactivated reason code.

What You Need to Do

Be aware that Reason Code A2 is being replaced by Reason Code 121 (Indemnification Adjustment) as of January 3, 2005.

Background

Change Request (CR) 2657 has changed the 835 flat file for carriers and DMERCs to accommodate quantity in metric units, which may have up to seven numeric positions and up to three decimal points. The updated flat file is posted at: ***www.cms.hhs.gov/providers/edi/hipaadoc.asp***

In addition, as noted above and effective as of January 1, 2005, Reason Code A2 will be replaced by Reason Code 121 (Indemnification Adjustment) on remittance advices.

Additional Information

The official instruction released to your carrier or DMERC may be found at: ***www.cms.hhs.gov/manuals/pm_trans/R103OTN.pdf***

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

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Medlearn Matters Number: MM3636
Related Change Request (CR) #: 3636

Related CR Release Date: January 21, 2005
Related CR Transmittal #: 436
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

The following information affects all Medicare providers.

Provider Action Needed

Impact to You

The July 2004 through October 2004 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. Your Medicare carrier or fiscal intermediary must use the latest approved and valid codes in 835 transactions, corresponding standard paper remittance advice, and coordination of benefits transactions.

What You Need to Know

The most current and complete code list will be found online at: ***www.wpc-edi.com/codes***. Please note that in case of a discrepancy, the code text included on this Washington Publishing Company (WPC) Web site will supersede any corresponding text in a Medicare Change Request (CR).

What You Need to Do

The above noted codes are updated three times a year. Please advise your billing staff to stay current with the latest approved and valid codes, in accordance with effective and implementation dates, to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.

Background

The Remittance Advice Remark Code list is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). This list is maintained by the Centers for Medicare & Medicaid Services (CMS) and is updated three times a year.

The Health Care Claim Adjustment Codes are maintained by the Claim Adjustment Reason Code and Status Code Maintenance Committee. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and decides on any additions, modifications, or retirement of reason codes. This updated list is also posted three times a year.

The complete list of current codes is available online at the WPC Web site: ***www.wpc-edi.com/codes***

Here is a summary of the current updates.

Remark Codes

- **New**

  New codes from N247 to N344 have been created to replace a number of generic remark codes, or to enable some existing codes to be split to better reflect their lowest component. This has been done to resolve some provider complaints that it is difficult for them to correlate certain remark codes with segments and data elements submitted on their corresponding claims. Codes with multiple meanings have been split, and new code(s) added to report each of the multiple bits of information previously included in a single message. For example,

  - M45 (Missing/incomplete/invalid occurrence codes or dates) has been modified to mean "Missing/incomplete/invalid occurrence code(s)," and N299 (Missing/incomplete/invalid occurrence date(s)) has been added to address the date portion of the prior message.
  - MA29 has been deactivated entirely and codes N256, N258, N261, N264, N266, N269, N279, N281, N285, N289, N292, N294, and N296 have been added to convey distinct types of information previously conveyed in MA29.

The following is a list showing the new codes and the source code that has been modified/split to create the new code:

New Code	Split from Existing Code
N299	M45
N300	M46
N301	M51
N302	M74
N303	MA66
N304	N57

Modified Remark Codes

The following table reflects modified remark codes:

Code	Current Modified Narrative	Modification Date
M67	Missing/incomplete/invalid other procedure code(s).	12/2/04
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.	12/2/04

Code	Current Modified Narrative	Modification Date
M45	Missing/incomplete/invalid occurrence code(s).	12/2/04
M46	Missing/incomplete/invalid occurrence span code(s).	12/2/04
M51	Missing/incomplete/invalid procedure code(s).	12/2/04
MA66	Missing/incomplete/invalid principal procedure code.	12/2/04
MA121	Missing/incomplete/invalid x-ray date.	12/2/04
MA122	Missing/incomplete/invalid initial treatment date.	12/2/04
N31	Missing/incomplete/invalid prescribing provider identifier.	12/2/04
N57	Missing/incomplete/invalid prescribing date.	12/2/04

Deactivated Remark Codes
Codes M57, M68, M108, M110, M120, M128, MA29, MA38, MA 52, MA82, MA105, MA127, and N145 have been deactivated.

Reason Codes

- **New**
  Code 165 has been added as of October 2004, and its narrative is "Payment denied/reduced for absence of, or exceeded referral."

Additional Information

The most recent changes approved for the Remittance Advice Remark Codes and the Claim Adjustment Reason Codes can be found in the official instruction issued to your carrier or fiscal intermediary, including Durable Medical Equipment Regional Carriers (DMERCs). That official instruction is found in CR 3636, which is available 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 the link for CR 3636. Click on the link to open and view the file for the CR. The CR attachments also include information on the process of the decision-making process that updates the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. It also includes a table of changes; however, please note that the most current and complete list is online at the WPC Web site. This CR includes changes made only from July through October of 2004.

If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll-free number at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

April 2005 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: MM3566
Related Change Request (CR) #: 3566
Related CR Release Date: December 17, 2004
Related CR Transmittal #: 408
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

The following information affects physicians, providers, and suppliers.

Provider Action Needed

Physicians, providers, and suppliers should note that this article and related CR 3566 provide information regarding updates to the Health Care Claims Status Codes and Health Care Claims Status Category Codes for use in requesting information about the status of claims with the Health Care Claim Status Request and Response ASC X12N 276/277 transactions. Effective April 1, 2005, Medicare carriers and intermediaries will use codes with the "new as of June 2004" designation and prior dates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directs that all health care plans to use national standards for the transfer of certain health care data. HIPAA requires all payers to use the applicable health care claims status category codes and health care claim status codes of the American National Standards Institute (ANSI) American Standards Committee (ASC) X12N. 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 transaction. These transactions are used by providers to inquire about the status of claims they have submitted and by health plans to reply to such inquiries.

Medicare contractors (carriers, Durable Medical Equipment Regional Carriers, intermediaries, and Regional Home Health Intermediaries) must update their claims systems to ensure that the current version of these codes is used in their claim status responses. By April 4, 2005, Medicare contractors are to use the "new as of June 2004" or a prior date designation. These codes may be found at: ***www.wpc-edi.com/codes/Codes.asp***

Not all of the codes apply to Medicare. Thus, Medicare contractors are not required to accommodate codes that do not apply to Medicare in their 277 responses.

Note: Medicare contractors must comply with the requirements contained in the version 4010A1 ASC X12 276/277 IG and must use valid Health Care Claim Status Category Codes and Health Care Claim Status Codes when sending 277 responses.

Additional Information

The Medicare Claims Processing Manual (Pub. 100-04), Chapter 31 (ANSI X12N Formats), Section 20 (ANSI X12N 276/277 Claims Status Request/Response Transaction Standard), Subsection 20.7, has been revised. The revised manual page(s) are attached to the official instruction released to your Medicare carrier/intermediary. You may view that instruction at: ***www.cms.hhs.gov/manuals/pm_trans/R406CP.pdf***

For additional information on claims status codes and claims status category codes, you may also refer to Medlearn Matters article MM3361, which is available at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3361.pdf***

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***

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***

News from DMERC A…

2005 Fee Schedules

The 2005 fee schedules are available via the "Fee Schedules" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site, ***www.umd.nycpic.com/dmfees.html***. Additional notices can be accessed via the "2005 Fee Schedule Article/ Information" link, including:

- Fee for J9000
- January 2005 Fee for HCPCS Code A4349

Furthermore, the following fees/updates have been posted:

- 1st Quarter 2005 Update: Drug Fees and Nebulizer Drug Fees
- Revision to January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File (Revised 2-17-05)
- 1st Quarter 2005 Update: Oral Anticancer Drug Fees
- 2005 Parenteral and Enteral Fees
- Payment Amounts for 2005 Oxygen & Oxygen Equipment

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

Suppliers without Internet access can request hard copy versions by writing to:

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

Reminders - CMS-1500 Form

The CMS-1500 form is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for billing of Medicare Part B covered services by non-institutional providers and suppliers, and it can be used for both assigned and non-assigned claims. To expedite claims processing, the Region A Durable Medical Equipment Regional Carrier (DMERC A) encourages

providers and suppliers to please refer to the following tips when preparing their CMS-1500 claims.

- Use only the CMS-approved format, which is an original red-and-white document, for initial claims. Photocopies and faxed documents are not acceptable for claims submission to DMERC A, except for resubmitted claims which are annotated as such (e.g., the word "Resubmit" is clearly written on the copy/fax).
- Be sure to complete Item 33 (Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field.**) for all claims. There have been cases where claims were submitted without this information.
- It is not necessary to submit claims via overnight mail or certified, unless a record of receipt by DMERC A is needed for documentation purposes (i.e., timely filing issues). Claims received via overnight mail or certified are not handled differently than those received via regular mail.

Instructions for completing CMS-1500 forms are contained within Chapter 3 of the DMERC A Supplier Manual (accessible via ***www.umd.nycpic.com/dmprovpublcopy.html***) and Chapter 26 of the CMS Internet Only Manual, Pub. 100-4, Medicare Claims Processing Manual (***www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf***). These instructions are also available on the CMS Web site at ***www.cms.hhs.gov/providers/edi/edi5.asp***.

EDI Services

ExpressPlus EDI Support Capabilities/Limitations

If you are currently using the Region A Durable Medical Equipment Regional Carrier (DMERC A) low cost ExpressPlus software, please take the time to read the article titled "ExpressPlus EDI Support Capabilities/Limitations," which can be accessed via the "HIPAA Compliant Software" section of the DMERC A Web site or directly at ***www.umd.nycpic.com/edisoftware.html#Caps/Limits***. ExpressPlus should not be tampered with. If the supplier has in-house information technology (IT) help and the DMERC A Electronic Data Interchange (EDI) Department concludes that the software has been tampered with or altered in any way, the EDI Department will not be responsible for supporting ExpressPlus. DMERC A EDI will only support the software in its original condition.

Web-based Training Sessions

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department is offering Web-based training sessions for the "Installation of ExpressPlus Software" and "ExpressPlus File Submission." To register for these Web-based training sessions, please visit the "Education-Tutorials" section of the DMERC A Web site (***www.umd.nycpic.com/dme-eduonline.html***) and click on the appropriate link(s).

In addition, please sign up for our EDI ListServe at ***www.umd.nycpic.com/edilistserve.html*** in order to be informed of future EDI-specific Web-based training sessions.

Use of the 835v4010A1 Electronic Remittance Advice

The need for providers to begin using the American National Standards Institute (ANSI) X12N 835 version 4010A1 HIPAA-compliant electronic remittance advice is imminent. Please note that once the Health Insurance Portability and Accountability Act (HIPAA) contingency plan is no longer in effect, the receivers of pre-HIPAA Electronic Remittance Notices (ERNs) who are not yet in production status for HIPAA Electronic Remittance Advices (ERAs) 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 recipient of electronic remittance transactions, fax a brief statement that you want to switch from the National Standard Format (NSF) ERNs to the ANSI ERAs, using your company letterhead for the request. If you

wish to be a new recipient of electronic remittance transactions, all you need to do is to fill out and fax the "ERN Addendum" form, 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, EDI has 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 may find this listing on our Web site at ***www.umd.nycpic.com/edidocfiles.html***.

Cut Your Transmission Time – Use of the Zip File Format

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Bulletin Board System (BBS) can accept production files that are submitted in a zipped file format. The zip file format allows for multiple files to be sent at once, and there's no limit to the number of files you can include within a zip file. Using the zip file format reduces your transmission time by compressing files - a zipped file can cut your transmission time in half.

If you are interested in this option, you must contact the DMERC A Electronic Data Interchange (EDI) Department to have your BBS account modified to receive zipped files. Once your account has been set up for zip files, you can only send zipped files. Be sure to contact your vendor to see if their software supports sending zip files.

The name of each file within the zip file must use the following standards:

- The file name must begin with the letter of your submitter number.
- The next four (4) characters of the file name must be the last four digits of your submitter number.
- The remaining three (3) characters of the file name should be a sequence number beginning with **001**.
- The file extension must be **.dat**.

Examples:

- If your submitter number is A08080808 and this is the third file you are adding to the zip file, the file name would be **a0808003.dat**.
- If your submitter number is B08839909 and this is the first file you are adding to the zip file, the file name would be **b9909001.dat**.

The name of the zip file being transmitted does not matter, as it will be renamed upon receipt.

For more information, please contact the EDI Department at 866-861-7348.

HIPAA Information

News from CMS…

Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims

Medlearn Matters Number: MM3440
Related Change Request (CR) #: 3440
Related CR Release Date: January 27, 2005 (CR Re-issued) **Revised**
Related CR Transmittal #: 450
Effective Date: July 1, 2005
Implementation Date: July 5, 2005
Note: This article was revised on January 31, 2005, to reflect a new CR release date and CR Transmittal number since the CR was re-issued. All other information in the article remains the same.

The following information affects all Medicare providers.

Provider Action Needed

Impact to You

If you don't submit your Medicare claims electronically, your payments could be affected (unless you meet specific exception criteria mentioned below).

What You Need to Know

ASCA prohibits Medicare from making payments on or after October 16, 2003, for claims that are not submitted electronically. You must submit your claims electronically, unless you meet one of the exceptions listed below.

What You Need to Do

Make sure that your billing staff submits your Medicare claims electronically. Or, if you believe that you meet one of the exception criteria, make sure that you appropriately complete the "Request for Documentation" letter from your carrier or fiscal intermediary to process your claims.

Background

Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires you, with limited exceptions, to submit all your initial claims for reimbursement under Medicare electronically, on or after October 16, 2003.

Further, ASCA amendment to Section 1862(a) of the Social Security Act (the Act) prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Consequently, unless you fit one of the exceptions listed below, any paper claims that you submit to Medicare will not be paid. In addition, if it is determined that you are in violation of the statute or rule, you may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

There are some exceptions to this electronic claim submission requirement. They include the following:

- You are a small provider - a provider billing a Medicare fiscal intermediary that has fewer than 25 Full-Time Equivalent employees (FTEs), and a physician, practitioner, or supplier with fewer than ten (10) FTEs that bills a Medicare carrier;
- A dentist;
- A participant in a Medicare demonstration project in which paper claim filing is required due to the inability of the Applicable Implementation Guide, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to report data essential for the demonstration;
- A provider that conducts mass immunizations, such as flu injections, and may be permitted to submit paper roster bills;
- A provider that submits claims when more than one other payer is responsible for payment prior to Medicare payment;
- A provider that only furnishes services outside of the United States;
- A provider experiencing a disruption in electricity and communication connections that are beyond its control; and
- A provider that can establish an "unusual circumstance" exists that precludes submission of claims electronically.

The process for post-payment based enforcement is as follows:

- Your Medicare contractor will analyze reports displaying the number of paper claims that all providers submitted each quarter.
- By the end of the month following the quarter, selected providers who have submitted the highest numbers of paper claims will be reviewed.
- Medicare contractors will ask these providers to provide information that establishes the exception criteria listed above.

If you, as one such provider, do not respond to this initial "Request for Documentation" letter within 45 days of receipt, your contractor will notify you by mail that Medicare will deny and not pay any paper claims that you submit beginning ninety (90) days after the date of the initial request letter. If you **do** respond to this initial letter, and your response does not establish eligibility to submit paper claims, the contractor will notify you by mail of your ineligibility to submit paper claims. This Medicare decision is not subject to appeal. In these letters, your Medicare contractor will also tell you how to obtain free and commercially available HIPAA-compliant billing software packages.

If you respond with information that does establish eligibility to submit paper claims, the contractor will notify you by mail that you meet one or more exception criteria to the requirements in Section 3 of the ASCA, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, and you will be permitted to submit paper claims.

However, you will be cautioned that if your situation changes to the point that you no longer meet the exception criteria, you will be required to begin electronic submission of your claims.

If you are permitted to submit paper claims, your carrier/intermediary will not review your eligibility to submit paper claims again for at least two (2) years.

Additional Information

You can learn more about the instructions issued to

your carrier/intermediary regarding ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Look for CR 3440 in the CR NUM column on the right, and click on the file for that CR. These instructions provide more detail on what constitutes an "unusual circumstance" that precludes submission of claims electronically.

You might also want to look at the online Manual Pub. 100-04, Chapter 24, Section 90, Subsection 5 (Enforcement). You can find this manual at:
www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf

If you have any questions, please contact your contractor at his/her toll-free number:
www.cms.hhs.gov/medlearn/tollnums.asp

News from DMERC A…

HIPAA Compliance - Conversion of Electronic Submitters

At the end of fiscal year 2004, approximately **96** percent of the Region A Durable Medical Equipment Regional Carrier (DMERC A) electronic claims were submitted using the American National Standards Institute (ANSI) X12N 837 4010A transaction standards.

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

For further information on HIPAA, visit the DMERC A Web site at:
www.umd.nycpic.com/emc&hipaa.html

National Council for Prescription Drug Programs (NCPDP) Error Code Manual

The National Council for Prescription Drug Programs (NCPDP) Error Code Manual is now available on the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site. To access the manual, visit the "EDI - Documents and Files" section at ***www.umd.nycpic.com/edidocfiles.html***, then click on the "NCPDP Error Code Manual" link.

The NCPDP Error Code Manual is provided as an Adobe Acrobat Portable Document Format (PDF) file. Please be sure to follow the "Instructions for Downloading and Viewing a PDF" listed on the above-mentioned section of our Web site.

General Information

News from CMS…

Influenza Treatment Demonstration

Medlearn Matters Number: MM3696
Related Change Request (CR) #: 3696
Related CR Release Date: January 21, 2005
Related CR Transmittal #: N/A
Effective Date: December 1, 2004
Implementation Date: January 17, 2005

The following information affects physicians, providers, and suppliers.

Provider Action Needed

Physicians, providers, and suppliers should note that Medicare will cover four new flu medications, including—where applicable—their generic equivalents. These medications are Amantadine Hydrocloride; Zanamivir, Inhalation Power Administered through Inhaler; Oseltamivir Phosphate, Oral; and Rimantadine Hydrochloide, Oral.

These drugs will be paid under a Centers for Medicare & Medicaid Services (CMS) Demonstration for dates of service through May 31, 2005. In addition, physicians, providers, and suppliers that enroll in Medicare before

May 31, 2005, may also file claims for drugs furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

Background

The Centers for Disease Control and Prevention (CDC) recommends that individuals in the following groups should be vaccinated against influenza annually:

- Adults aged 65 years and older;
- Residents of nursing homes and long-term care facilities; and
- Those with underlying chronic medical conditions.

Early in the flu vaccination season it was reported that there would be a shortage of vaccine due to manufacturing problems. Although it appears that there will be ample flu vaccine, many Medicare beneficiaries may not have been vaccinated and remain at risk. Vaccination against flu is still the best protection; however, for those Medicare beneficiaries who have been unable to receive a flu vaccination, the next best approach to protect them is to provide coverage for antiviral medicines that can prevent the complications of influenza infection by reducing the duration and severity of the infection. The shorter the duration of the infection, the less time the individual is contagious to others. In some cases, the antiviral medicine can also act as a primary preventive agent.

Influenza Treatment Demonstration

CMS is undertaking a demonstration project to measure the impact of providing coverage for certain antiviral drugs to treat and/or prevent influenza. The Influenza Treatment Demonstration will provide coverage to Medicare beneficiaries for Food and Drug Administration (FDA)-approved drugs for the treatment and targeted prevention of influenza.

Specifically, under this demonstration, Medicare will cover certain anti-viral drugs when furnished:

- To a beneficiary with symptoms of influenza;
- As a prophylaxis for a beneficiary exposed to a person with a diagnosis of influenza; or
- To a beneficiary in an institution where there has been an outbreak of influenza.

However, the demonstration does **not** cover these anti-viral drugs for general prophylactic use.

The following drugs (including, when applicable, bioequivalents or generic equivalents) are included in the demonstration:

- Amantadine Hydrocloride, Oral;
- Zanamivir, Inhalation Power Administered through Inhaler;
- Oseltamivir Phosphate, Oral; and
- Rimantadine Hydrochloide, Oral.

The drugs under this demonstration must be furnished incident to a physician service or must be prescribed by a physician (or other practitioner authorized by state law to prescribe such drugs). Except as noted below, all ancillary Medicare rules apply to the furnishing of these drugs to Medicare beneficiaries under this demonstration. Also, information regarding treatment and drug dosage of these influenza antiviral medications is included in the Additional Information Section of this special edition.

The demonstration will include dates of service through May 31, 2005. Also, note that all claims for drugs furnished under this demonstration **must be filed no later than December 31, 2005**.

Physicians, providers, and suppliers that enroll in Medicare before May 31, 2005, may also file claims for drugs furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

Payment Amounts

Both the Medicare co-payment and deductible apply to all claims under this demonstration, including claims for Medicare Advantage (MA) beneficiaries. The exception is in the calculations of co-payments for beneficiaries participating in the Drug Discount Card program. These beneficiaries will pay the lesser of 20% of the Medicare allowable amount or 20% of the negotiated Drug Discount Sponsor's price for antiviral medicines, plus $.20 (20% of a $1.00 administrative charge). A chart explaining how to do the calculations for determining co-payment amount for Drug Discount Card participants is attached. CMS will also make this chart available on its Web site at ***www.cms.hhs.gov/researchers/demos/flu*** and will update cost information monthly. Finally, no deductible will apply to claims from Federally Qualified Health Centers (FQHCs).

Except as noted below, the Medicare allowed amount for these demonstration drugs will be based on 95% of the average wholesale price (AWP) for the brand name of each drug (Zanamivir and Oseltamivir Phosphate) covered under this demonstration, determined in accordance with customary Medicare payment policy. For drugs marketed as bioequivalent or generics (Amantadine and Rimantadine), the allowed amount will be based on 90% of AWP.

For the duration of the demonstration, the allowed Healthcare Common Procedure Coding System (HCPCS) codes/charges are as follows:

- G9017: Amantadine Hydrocloride, Oral, per 100 mg, (for use in a Medicare-approved demonstration project), $0.76.
- G9018: Zanamivir, Inhalation Powder Administered Through Inhaler, per 10 mg, (for use in a Medicare-approved demonstration project), $5.43.
- G9019: Oseltamivir Phosphate, Oral, per 75 mg, (for use in a Medicare-approved demonstration project), $6.99.
- G9020: Rimantadine Hydrochloride, Oral, per 100 mg, (for use in a Medicare-approved demonstration project), $1.65.
- G9033: Amandatine Hydrocloride, oral, brand, per 100 mg (for use in a Medicare-approved demonstration project), $1.32.
- G9034: Zanamivir, Inhalation Powder Administered Through Inhaler, brand, per 10 mg, (for use in a Medicare-approved demonstration project), $5.43.
- G9035: Oseltamivir Phosphate, Oral brand, per 75 mg, (for use in a Medicare-approved demonstration project), $6.99.
- G9036: Rimantadine Hydrochloride, Oral brand, per 100 mg, (for use in a Medicare-approved demonstration project), $2.17.

Those entities that are to be paid on a basis other than of 90% or 95% of AWP are as follows:

- Indian Health Service (IHS) hospitals will be reimbursed on the basis of the outpatient all-inclusive rate.
- IHS Critical Access Hospitals (CAHs) will be reimbursed on the basis of a facility-specific visit rate.
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will be reimbursed on the basis of the all-inclusive rate when one of the drugs is furnished as part of a billable encounter under revenue code 052X. An encounter cannot be billed if furnishing the drug is the only service the RHC/FQHC provides. (Although the provision of these drugs in and by themselves does not constitute a billable encounter in the RHC/FQHC setting, the cost of the drugs can be claimed on the RHC/FQHC cost report and bundled into the all-inclusive payment rate calculation.)
- Maryland hospitals that are under the jurisdiction of the Health Services Cost Review Commission (HSCRC) are paid under the Maryland waiver.

Billing Instructions

Claims for drugs furnished under this demonstration may be submitted by enrolled Medicare providers as follows: hospitals including CAHs, skilled nursing facilities (SNFs), renal dialysis facilities (RDFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Home Health Agencies (HHAs), and by enrolled physicians, other practitioners, or other suppliers that are authorized under state law to dispense these drugs.

Except as noted below, providers, physicians, and other suppliers must follow customary Medicare billing and claims processing rules.

- An entity possessing a supplier number issued by the National Supplier Clearinghouse (NSC) must bill the Durable Medical Equipment Regional Carrier (DMERC) having jurisdiction for the location of the beneficiary's permanent residence.
- All hospitals (other than Indian Health Service (IHS) hospitals, IHS-CAHs, Maryland hospitals as noted above, and hospitals which do not have a supplier number issued by the NSC) must bill the appropriate DMERC using the CMS-1500 or electronic equivalent. Otherwise, billing by the hospital is to the fiscal intermediary on the CMS-1450/UB-92 or electronic equivalent.
- All other institutional providers, not possessing an NSC-issued supplier number, must bill the fiscal intermediary on the CMS-1450/UB-92 or electronic equivalent.
- All physicians, practitioners, and other suppliers, not possessing an NSC-issued supplier number, must submit claims to their local area carrier using the CMS-1500 or electronic equivalent.
- HHAs should follow billing requirements already in place for vaccines when billing for these drugs as specified in Pub. 100-4, Chapter 18, Section 10.2.3, which may accessed at ***www.cms.hhs.gov/manuals/104_claims/clm104index.asp***.
- All institutional providers billing their fiscal intermediary must submit a separate claim for these drugs.
- Roster billers submit claims in accordance with the instructions specified in Pub.100-4, Chapter 18, Section 10.3, except:

- HCPCS codes G0008, G0009, 90657, 90658, 90659, and 90732 should not be reported on the same roster bill under this demonstration;
- An administration fee will not be paid for drugs administered under this demonstration;
- Roster billers must bill different dates of service, dosages, codes, and quantities on different roster or claims forms; and
- Payment may be made for MA beneficiaries under this demonstration and such claims should be reported to the provider's regular carrier or intermediary.
- Medicare Advantage (MA) plans, if enrolled in fee for service billing, must bill for these items using their normal procedures for billing for Medicare Fee-For-Service items and services. Providers and suppliers may submit claims for MA beneficiaries to their normal FI or carrier.

Acceptance of assignment is mandatory for all claims submitted under this demonstration and Medicare Secondary Payer (MSP) rules apply to claims under this demonstration.

Implementation

The implementation date for this instruction is January 17, 2005.

Additional Information

Treatment and Drug Dosage of Influenza Antiviral Medications[1]

You are referred to the Centers for Disease Control and Prevention Web site (Antiviral Agents for Influenza (Background Information for Clinicians)) at: ***www.cdc.gov/flu/professionals/antiviralback.htm***

Treatment

For the treatment of influenza, controlled studies have found that neuraminidase inhibitor drugs (Zanamivir, Oseltamivir) and adamantane derivative drugs (Amantadine, Rimantadine) administered within 48 hours of illness onset, decrease viral shedding and reduce the duration of influenza A illness by approximately one (1) day compared with placebo. The usual recommended duration of treatment is five (5) days.

Chemoprophylaxis

Known exposure: For chemoprophylaxis of known exposure, treatment should begin within two (2) days of contact with an infected individual and continue for two (2) weeks.

In lieu of vaccination: To be maximally effective as prophylaxis in lieu of vaccination, influenza antiviral medications must be taken each day for the duration of influenza activity in the community. However, one study of amantadine or rimantadine prophylaxis reported that the drugs could be taken only during the period of peak influenza activity in a community.[2]

Outbreak in an institution: For residents of an institution, chemoprophylaxis is recommended during an outbreak, and should be continued for at least two weeks. If surveillance indicates that new cases continue to occur, chemoprophylaxis should be continued until approximately one week after the end of the outbreak.

Dosage:

Recommended Daily Dosage of Influenza Antiviral Medications for Treatment and Prophylaxis[3]		
Antiviral Agent	Age Groups (yrs)	
	13-64	> 65
Amantadine* (Symmetrel®)		
Treatment, influenza A	100mg twice daily §	< 100 mg/day
Prophylaxis, influenza A	100mg twice daily §	< 100 mg/day
Rimantadine (Flumadine®)		
Treatment, ** influenza A	100mg twice daily §§	100 mg/day
Prophylaxis, influenza A	100mg twice daily §	100 mg/day
Zanamivir*†† (Relenza®)**		
Treatment, influenza A and B	10mg twice daily	10mg twice daily
Oseltamivir (Tamiflu®)		
Treatment, §§§ influenza A and B	75mg twice daily	75mg twice daily
Prophylaxis, influenza A and B	75mg/day	75mg/day

* The drug package insert should be consulted for dosage recommendations for administering amantadine to persons with creatinine clearance < 50 ml/min/1.73m 2.

† 5 mg/kg of amantadine or rimantadine syrup = 1 tsp/22 lbs.

§ Children > 10 years who weigh <40 kg should be administered amantadine or rimantadine at a dosage of 5 mg/kg/day.

A reduction in dosage to 100 mg/day of rimantadine is recommended for persons who have severe hepatic dysfunction or those with creatinine clearance < 10 mL/min. Other persons with less severe hepatic or renal dysfunction taking 100 mg/day of rimantadine should be observed

closely, and the dosage should be reduced or the drug discontinued, if necessary.

** Only approved by FDA for treatment among adults.

§§ Rimantadine is approved by FDA for treatment among adults. However, certain experts in the management of influenza consider it appropriate also for treatment among children. (See American Academy of Pediatrics, 2000 Red Book.)

Older nursing-home residents should be administered only 100 mg/day of rimantadine. A reduction in dosage to 100 mg/day should be considered for all persons aged > 65 years if they experience possible side effects when taking 200 mg/day.

*** Zanamivir administered via inhalation using a plastic device included in the medication package. Patients will benefit from instruction and demonstration of the correct use of the device.

††† Zanamivir is not approved for prophylaxis.

§§§ A reduction in the dose of oseltamivir is recommended for persons with creatinine clearance <30 ml/min.

Further Claims Preparation Instructions

Because Medicare carriers will hold claims received until Medicare systems changes are made on January 17, 2005, interest will be paid to providers, where applicable, when the held claims are processed on or after January 17, 2005. In addition, physicians, providers, and suppliers should note the following:

- The type of service code for these claims is "1."
- An appropriate diagnosis code must be included on the claim in order to be Health Insurance Portability and Accountability Act (HIPAA)-compliant.
- Carriers will apply the 5% reduction in payment on claims from non-participating physicians.
- Assignment is mandatory for all claims filed under this demonstration.
- Providers billing for services under this demonstration for hospice patients should include condition code 07 on the claim.
- Hospitals, SNFs, CORFs, Renal Dialysis Facilities, CAHs, IHS hospitals, and IHS CAHs should use revenue code 0636 along with the appropriate HCPCS code.
- Billing for codes G9017, G9018, G9019, G9020, G9033, G9034, G9035, or G9036 must be done on separate claims and **no other codes may be present on such claims**.
- For claims submitted to intermediaries, providers should use types of bill (TOB) 12X, 13X, 22X, 23X, 34X, 72X, 75X, or 85X. **Claims submitted with any other TOB for services under this demonstration will be returned to the provider**.
- Drugs covered under this demonstration will be payable even if the beneficiary has already received a flu vaccine.
- Beneficiaries may receive no more than two of the drugs permitted under this demonstration (e.g., the same drug twice or a combination of two different drugs).
- Medicare will not pay for code G0008 (administration fee) under this demonstration.

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

From that Web page, look for CR3696 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

[1] Source: ***www.cdc.gov/mmwr/preview/mmwrhtml/rr5306a1.htm***

[2] Patriarca PA, Arden NH, Koplan JP, Goodman RA. Prevention and control of type A influenza infections in nursing homes: benefits and costs of four approaches using vaccination and amantadine. Ann Intern Med 1987;107:732—40.

[3] ***www.cdc.gov/flu/professionals/antiviralback.htm***

ATTACHMENT: Please refer to the "Link to Beneficiary Copayment Calculator" on CMS' Web site (***www.cms.hhs.gov/researchers/demos/flu***) for the current cost information.

INSTRUCTIONS FOR USING THIS TABLE

NOTE: This table is only used to calculate the beneficiary co-payment amount for those participating in the Medicare Drug Discount Card Program.

1. Locate the name of the Medicare Drug Discount Card Sponsor in column A, or the Sponsor's plan number in column B.
2. Locate the prescribed medicine in column C through I.
3. Find the cost per unit for the prescribed medicine for the specific Card Sponsor.
4. Multiply the unit cost of the medicine by the number of units in the prescription, PLUS $1.00, to calculate the total Drug Card Sponsor's cost.
5. Multiply the Medicare Allowed Payment Amount by the number of units in the prescription to calculate the Medicare allowed cost.
6. Compare the total cost of the Drug Card Sponsor with the total cost of the Medicare allowed cost.
7. If the total Medicare allowed cost is less than the total

Drug Card Sponsor's cost the co-payment will be 20% of the Medicare Allowed cost.

8. If the total Drug Card Sponsor's cost is less than the Medicare allowed cost the co-payment will be 20% of the Drug Card Sponsor's costs.

** In either case Medicare will reimburse the pharmacy 80% of the Medicare allowed cost.

Coming Soon - The New Medicare Prescription Drug Program

Medlearn Matters Number: SE0501
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The First in a Series of Medlearn Matters Articles for Providers On Medicare's New Prescription Drug Program

The following information affects all physicians, providers, suppliers, and their staff providing service to people with Medicare.

Provider Action Needed

Impact to You

On January 1, 2006, a very important new benefit will be available to your Medicare patients. These new Medicare Prescription Drug Plans will be of significant value to your patients by providing assistance with prescription drug expenses. This program is authorized under the Medicare Modernization Act of 2003 (MMA). Your patients may ask you about this new benefit.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is preparing an extensive campaign for both providers and beneficiaries, and will be disseminating information to these audiences. Over the next year, as materials are developed, you will be notified through a series of Medlearn Matters articles and other resources. Some providers will choose to be active in giving information to their Medicare patients, and we will help you do that. CMS encourages and appreciates the work providers are willing to do to help people with Medicare learn about this important new benefit.

What You Need to Do

Stay informed. Go to the newly established Web site, ***www.cms.hhs.gov/medicarereform/pdbma/***, and check it often as new information is always being added. This easy-to-use Web site has a "General Information" link to the press releases, issue papers, fact sheets, and full copies and summaries of both regulations. Users can follow the menu and select the area that best matches their area of interest. Refer your Medicare patients to information resources – **1-800-MEDICARE** and ***www.medicare.gov***.

Background

On December 8, 2003, the Medicare Modernization Act (MMA) was enacted, adding a very important new benefit to the Medicare program. This new benefit takes effect on January 1, 2006, and provides a much needed new drug benefit to help serve the 41 million Americans who rely on Medicare for their health care needs.

On January 21, 2005, Health and Human Services Secretary Tommy G. Thompson announced the final regulations establishing the new Medicare prescription drug benefit program. This is a very important step in making this great addition to the Medicare program a reality for your Medicare patients.

This is a very special time for your patients with Medicare, full of many exciting program improvements and enhancements. Great opportunities exist right now, through the MMA, to make the Medicare program more personalized and more up-to-date, and to keep it up-to-date. The Medicare Drug Benefit is a major step in that direction. A very important step toward fulfilling that opportunity is in the final regulation for the Medicare Drug Benefit Program. Along with the new Medicare Preventive benefits, this major program improvement brings Medicare's coverage up-to-date with twenty-first century prevention-minded medicine.

WE NEED YOUR HELP

Because people with Medicare trust their physicians, other clinicians, pharmacists, and other health care providers, you are in a unique position to direct them to the resources available to help them learn about the new benefit. If any of your patients rely on caregivers, CMS appreciates your efforts to get this information into their hands as well.

CMS will be pursuing a number of activities to make sure the physician, provider, and supplier communities know about this new benefit, understand how it works,

and will be highlighting the information that may be of most value to your Medicare patients. As educational materials are developed, you will be notified of their availability. These materials will help you and your staff understand the new benefit. CMS will keep you up-to-date with education and outreach efforts on the new drug benefit. Here's how you can stay connected:

- Pay attention to correspondence from your Medicare carrier or fiscal intermediary or your national professional associations—they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their ListServes and read their newsletters;
- Register to receive ListServes email messages to alert you when new Medlearn Matters articles have been released on the new drug benefit (and other Medicare information). Medlearn Matters articles provide succinct and timely messages on Medicare claims processing and other changes. These articles can be found on the Web at: ***www.cms.hhs.gov/medlearn/matters***
- Participate in CMS Open Door Forums to hear from and ask questions of CMS leadership on topics of interest to your particular provider-type. Information regarding these Open Door Forums may be found on the Web at: ***www.cms.hhs.gov/opendoor***

CMS Doctors' Office Quality Information Technology Demonstrations: Providing Leadership in the Adoption of Electronic Health Records

Recent studies have highlighted the potential for Healthcare Information Technology (HIT) to improve the quality, safety, and efficiency of healthcare. Additionally, the Medicare Modernization Act of 2003 encourages the use of HIT to manage the clinical care of beneficiaries.

Through its role as a major payer of healthcare services and sponsor of both the largest national quality improvement program in the nation and innovative disease management demonstrations, the Centers for Medicare & Medicaid Services (CMS) is actively engaged in fostering IT integration in the nation's health care system. The CMS Doctors' Office Quality Information Technology (DOQ-IT) is a major project created to promote Electronic Health Records (EHR) in ambulatory care. This two-year Special Study demonstration is designed to improve quality of care, patient safety, and efficiency for services provided to Medicare beneficiaries by promoting the adoption of Electronic Medical Records (EMR)/Electronic Health Records (EHR) and HIT in primary care physician offices.

For additional information, please see the informational article on CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0505.pdf

Implementation of Section 921 of the Medicare Modernization Act (MMA) – Provider Customer Service Program

Change Request (CR) 3376 implements Section 921 of the Medicare Modernization Act. It creates the Provider Customer Service Program at most Medicare contractors; however, Durable Medical Equipment Regional Carriers (DMERCs) are not required by the Centers for Medicare & Medicaid Services (CMS) to implement CR 3376 at this time.

For more information on this CMS initiative, please refer to the Medlearn Matters article at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3376.pdf

CMS Seeks Provider Input on Satisfaction with Medicare FFS Contractor Services

The Medicare Contractor Provider Satisfaction Survey (MCPSS), a new pilot initiative sponsored by the Centers for Medicare & Medicaid Services (CMS), is designed to collect data on provider satisfaction with and perceptions about the services provided by Medicare Fee-for-Service (FFS) Contractors. HealthNow New York Inc. Region A Durable Medical Equipment Regional Carrier (DMERC A) was selected by CMS as one of twelve contractor participants for

this pilot. HealthNow New York Inc. DMERC A would like to stress the importance of provider participation for the success of this project. For further information, visit:
www.cms.hhs.gov/providers/mcpss/default.asp

News from DMERC A…

Reminder Regarding the Toll-Free Line for Beneficiaries – 1-800-MEDICARE

The Region A Durable Medical Equipment Regional Carrier (DMERC A) has been receiving calls on our provider toll-free line from beneficiaries who state their provider gave them the telephone number. We'd like to remind all providers that when you advise your patients to call Medicare for information, please direct them to call **1-800-MEDICARE (1-800-633-4227)**.

Program Education & Training

Billing Reminder: Glucose Monitor Supplies

When billing for glucose monitor supplies, one (1) unit of service equals 50 test strips for code A4253, and one (1) unit of service equals 100 lancets for code A4259. For example:

- If billing A4253 for 100 test strips, use two (2) units of service
- If billing A4259 for 100 lancets, use one (1) unit of service
- If billing A4253 for 200 test strips, use four (4) units of service
- If billing A4259 for 200 lancets, use two (2) units of service

Billing incorrect units of service cannot be corrected through our telephone redetermination process. These errors must be resolved through a **written** redetermination request. By billing the correct units of service, you will decrease your redetermination requests and save your company time and money.

For more information on coverage, coding, and documentation requirements, please refer to the current Glucose Monitors medical policy, which can be found on the Region A Program Safeguard Contractor (PSC) Web site at:
www.tricenturion.com/content/lmrp_current_dyn.cfm

Assignment of Dually Eligible Beneficiary Claims

The Program Education & Training (PET) Department would like to remind the supplier community of a specific processing change in Change Request (CR) 3218. Nonassigned Medicare claims cannot be forwarded to Medicaid. Therefore, effective July 1, 2004, any nonassigned claim with service dates during a period when a beneficiary is eligible for Medicaid will have the assignment changed to assigned for further processing.

CR 3218 can be found on the Centers for Medicare & Medicaid Services (CMS) Web site at:
www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf

Are You Moving?

If you have moved, or are planning to move, and have not yet sent in a "Change of Information" form (CMS-855S), be sure to notify the National Supplier Clearinghouse (NSC) of your new address immediately. If you wait, your payments can be suspended.

When an item is sent to a supplier's "Pay To" address and is returned by the U.S. Postal Service noting "Do Not Forward" (DNF), the Region A Durable Medical Equipment Regional Carrier (DMERC A) places a DNF code on the supplier's file. The DNF code suspends payments for that supplier number. The supplier must then verify their address with the NSC in writing.

Keep in mind, a request to change your address should not be sent to DMERC A since we cannot change supplier files. For more information, please refer to the

article titled "Updating Supplier Records," which can be found on page 28 of the September 2004 *DMERC Medicare News*.

DMERC A Forms

The Region A Durable Medical Equipment Regional Carrier (DMERC A) has created a cover sheet for Advance Determination of Medicare Coverage (ADMC) requests that are sent into our office. Recently, we have found that the ADMC requests DMERC A receives are not always identified as an ADMC request. As a result, the request would be routed to the incorrect department and not processed as an ADMC request. With the creation of the cover sheet, ADMC requests will be identified more readily and processed appropriately. The "ADMC Request" form can be found on our Web site at ***www.umd.nycpic.com/ADMCform.html***.

Previously when requesting an ADMC, suppliers would use the "Prior Authorization" option on the additional documentation cover sheet. As a result of the ADMC Request form, the additional documentation cover sheet has been updated to reflect the change. When sending in additional documentation, please use the updated cover sheet that can be found on our Web site at ***www.umd.nycpic.com/extra.html***.

The fax number for submitting ADMC requests or additional documentation is 570-735-9402. Please remember to only fax documents **once**, since multiple faxes impact the time that it takes to process the documentation accurately. When faxing added documentation for electronic claims, which should be done a minimum of two business days prior to submitting the claim, do **not** send a copy of the claim with the documentation. Instead, notate the date the fax was sent in the appropriate field(s).

In order to further decrease the quantity of added documentation that is faxed and mailed, DMERC A has updated the "Suggested Abbreviations When Reporting Additional Documentation Notations in the ANSI and NCPDP Formats." This suggested list is available via our Web site at ***www.umd.nycpic.com/edidocfiles.html#Abbrev***.

DMERC A would also like to remind suppliers that when faxing a request for a fair hearing, there is a "Fair Hearing Request Form" for your use, which can be found on our Web site at ***www.umd.nycpic.com/hearings-req-form.pdf***.

Claim Submission Errors for the First Quarter of Fiscal Year 2005

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 October 1, 2004, through December 31, 2004, are provided in the following chart. The total number of ANSI errors for this period was **189,202**.

ANSI Error Number - Narrative (Total Errors)	Reason for Error
1) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question (37,830 errors)	The question number entered is not valid for the DMERC CMN you are sending.
2) 40022 - Procedure Code/ Modifier Invalid (29,447 errors)	The procedure code and/or modifier used on this line is invalid.
3) 40073 - Dates of Service Invalid with Procedure (14,632 errors)	The procedure code used is not valid for the dates of service used.
4) 20025 - Subscriber ID Code Invalid (5,990 errors)	Subscriber ID code entered is not in a valid format.
5) 20143 - Ordering Provider Secondary ID Invalid (5,590 errors)	If indicating that you are sending in a Medicare provider number, you must send in a valid provider number. When indicating you are sending a provider Unique Physician Identification Number (UPIN), you must send in a valid UPIN number.
6) 40067 - Invalid/Unnecessary CMN Version Submitted (5,583 errors)	The DMERC CMN version number entered is not valid for the Healthcare Common Procedure Coding System (HCPCS) code submitted.
7) 40066 - Invalid/Unnecessary CMN Submitted (5,458 errors)	The DMERC CMN form number entered is not valid for the HCPCS code submitted.
8) 40021 - Capped Rental K Modifier Missing (5,326 errors)	The procedure code submitted requires a K modifier for adjudication.
9) 40037 - Service Date Greater Than Receipt Date (4,987 errors)	Service date is greater than date claim was received.
10) 40036 - Service Date Does Not Equal "To" Date (4,487 errors)	The procedure code submitted does not allow for spanned dates of service.

In an effort to reduce other initial claim denials, the below information represents the top ten return/reject denials for the first quarter of fiscal year 2005. 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) 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. (22,175 claims)	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity. You may enter up to four codes in priority order (i.e., primary, secondary condition).
2) CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure codes(s) and/or rates. (14,508 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.
3) CO 16 M78 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid HCPCS modifier. (6,227 claims)	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable, show HCPCS modifiers with the HCPCS code.
4) CO 16 MA83 Claim/service lacks information which is needed for adjudication. Did not indicate whether we are the primary or secondary payer. (5,550 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 MA102 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider. (5,028 claims)	**Item 17** - Enter the name of the referring or ordering physician, if the service or item was ordered or referred by a physician.
6) CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid place of service. (4,653 claims)	**Item 24B** - Enter the appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed.
7) CO 16 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. (3,806 claims)	**Item 33** - Enter the provider of service/supplier's billing name, address, zip code, and telephone number. Enter the Physician Identification Number (PIN) for the performing provider of service/supplier who is not a member of a group practice. Enter the group PIN for the performing provider of service/supplier who is a member of a group practice.
8) CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different. (2,958 claims)	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.
9) CO 16 M79 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid charge. (367 claims)	**Item 24F** - Enter the charge for each listed service.
10) CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid information on where the services were furnished. (273 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.

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!

Spring 2005 Seminars

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department announces the spring 2005 continuing education seminars and workshops. These sessions are being offered at **no charge**. Topics for the

sessions include DMERC 101, Documentation, Medicare Program Billing Updates, and Troubleshooting DMERC Claims/Getting It Right The First Time. The seminars are being offered as two-day sessions; however, you may attend any session(s) you wish. Please visit the "Events" section of the DMERC A Web site (***www.umd.nycpic.com/dmprovcaln.html***) for more information, including details on what will be covered in each session.

Dates and Locations

Date	Location	Address	Telephone
April 13-14, 2005	Hilton Parsippany	One Hilton Court Parsippany, NJ	973-267-7373
April 18-19, 2005	Sheraton Station Square	300 West Station Square Drive Pittsburgh, PA	412-261-2000
April 21-22, 2005	Ambassador Banquet & Conference Center at the Courtyard by Marriott	7794 Peach Street Erie, PA	814-860-8300
April 26-27, 2005	Prime Hotel and Conference Center	534 Broadway Saratoga Springs, NY	518-584-4000
May 2-3, 2005	Radisson Valley Forge	1160 First Avenue King of Prussia, PA	610-337-2000
May 18-19, 2005	Hyatt Harborside at Logan Airport	101 Harborside Drive Boston, MA	617-568-1234

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 PET 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.

Educational Tutorials

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department has educational tutorials available seven (7) days a week, 24 hours a day. These are great sessions to train new employees or refresh your knowledge on basic DMERC topics. The tutorials that are currently available include: Advance Beneficiary Notice (ABN), Capped Rental and Capped Rental Modifiers, DMEPOS Payment Categories, DMERC Forms that Relate to Medical Necessity, DMERC Resources, Navigating the DMERC A Web site, Remittance Notices, and Installation of ExpressPlus Software.

Upcoming tutorials will include Medicare Secondary Payer Billing, Introduction to DMERC, Guiding You Through the Provider Response Unit, Life of an ANSI Claim, and Refractive Lens Billing. To access the tutorials, please visit the "Education-Tutorials" section of the DMERC A Web site at ***www.umd.nycpic.com/dme-eduonline.html***.

In addition to the tutorials, information pertaining to current and/or upcoming live online sessions is available via the "Events" section at ***www.umd.nycpic.com/dmprovcaln.html***.

Stay informed - visit the DMERC A Web site on a regular basis for information on current and upcoming educational opportunities and events, including in-person functions such as industry trade shows and conferences.

Web Site Resources

News from CMS…

How to Locate Specific Transmittals/Change Requests (CRs) of Interest That Are Posted on Centers for Medicare & Medicaid Services (CMS) Web Sites

Medlearn Matters Number: SE0506
Special Edition Article #: SE0506
Related Change Request (CR) #: NA
Implementation Date: January 14, 2005

The following information affects all Medicare physicians, providers, suppliers, and others who use the Medlearn Matters articles and related Change Request (CR) information.

Provider Action Needed

This Special Edition article has been written to assist physicians, providers, and suppliers in locating specific CRs of interest that the Centers for Medicare & Medicaid Services (CMS) has issued and posted on its Web site.

Background

CMS Program Transmittals/Change Requests (CRs) are used to communicate new or changed policies, and/or procedures that are being incorporated into a specific CMS program manual, and Medlearn Matters articles are written about selected CMS Transmittals/Change Requests to assist providers in understanding these transmittals. Each Medlearn Matters article usually has a section included at the end of the article titled *Additional Information* that includes a variation of the following statement:

> *For complete details (regarding this Change Request XXXX), please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at:*
> ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***
>
> *From that Web page, look for the CR XXXX in the CR NUM column on the right, and click on the file for that CR.*

Note: The above Web site **includes Transmittals/CRs issued for the current year**. Therefore, starting in January 2005, the above Web site includes only those Transmittals/CRs with communication (comm.) release dates during calendar year 2005.

However, if you scroll down to the end of the above Web site page, you will find options for being redirected to Web sites for Transmittals/CRs issued in previous years (2000 through 2004).

An abbreviated copy/view of the above CMS Web site screen is shown below:

Medicare & Medicaid
2005 Program Transmittals/Program Memos

Table of Contents

SIZE	FILE	COMMUNICATION (COMM) DATE	MANUAL	SUBJECT	IMPLEMENTATION DATE	CR NUM
51 kb	R425CP	1/11/2005	PUB 100-04	Section 630 of the …	4/3/2005	3521
168 kb	R423CP	1/6/2005	PUB 100-04	January 2005 Update of the …	1/14/2005	3632

The files listed above are **PDF (Portable Document Format) files. In the past, the transmittal cover page was all we were able to put on the Internet. PDF format enables us to put the entire transmittal on the Internet. You can view and print PDF files exactly as they were originally printed in paper form. To view these documents, you must have the Adobe Acrobat Reader, which can be downloaded at no cost at:
Adobe Reader - Download - http://www.adobe.com/products/acrobat/readstep2.html

2004 Transmittals | 2003 Transmittals | 2002 Transmittals | 2001 Transmittals

Accessing CRs released prior to January 1, 2005

If you want to review a Transmittal/CR with a release date in a previous year, you can select the desired year, and you will be redirected to one of the following Web sites:

- 2004 - **http://www.cms.hhs.gov/manuals/pm_trans/2004/transmittals/comm_date_dsc.asp**
- 2003 - **http://www.cms.hhs.gov/manuals/pm_trans/2003/transmittals/comm_date_dsc.asp**
- 2002 - **http://www.cms.hhs.gov/manuals/pm_trans/2002/transmittals/comm_date_dsc.asp**

- 2001 - **http://www.cms.hhs.gov/manuals/pm_trans/2001/transmittals/comm_date_dsc.asp**
- 2000 - **http://www.cms.hhs.gov/manuals/pm_trans/2000/transmittals/comm_date_dsc.asp**

Once you have accessed the desired Transmittal/CR Web site, you can **sort** the Table of Contents (example shown above) by clicking your mouse on any column heading. To reverse the order of the sort for that column, click on the sort order icon (▲ or ▼).

For some users, once you have accessed the desired Transmittal/CR Web site, type Ctrl F (i.e., hold down the Control (Ctrl) key first, then press the 'f' key), and a 'Find' box will appear. Type the desired CR number in the 'Find What?' box, press the enter key, and you will be taken directly to the CR of interest which will be highlighted.

Additional Information

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

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The 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

The Pulse of CMS

The Centers for Medicare & Medicaid Services (CMS) provided the Region A Durable Medical Equipment Regional Carrier (DMERC A) with a copy of the Winter 2004 edition of "The Pulse of CMS." This quarterly regional publication, for health care professionals, is available via the "Education - Articles and Publication Highlights" section of the DMERC A Web site at ***www.umd.nycpic.com/dmeduc.html***. (**Note**: This is a Portable Document Format (PDF) file, therefore, please follow the PDF download instructions.)

News from DMERC A…

Supplier Manual News

The 2003 edition of 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*, including revised chapters and archived revisions. The 2003 edition is available to current suppliers via the DMERC A Web site **only**, and newly-enrolled suppliers will continue to receive initial hard copy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

Corrections/updates have been made to the manual as indicated below:

Revision 2003-08 (December 2004)

- Chapter 3 (Health Insurance Claim Form) - updated to reflect current information, as in Change Request (CR) 3431 and related sections of the CMS Online Manual System

Revision 2003-09 (March 2005)

- Chapter 1 (Contact Information) - updated to reflect the addition of the Program Inquiries Voicemail Line and hours of operation were added for the other DMERC offices, the Statistical Analysis DMERC (SADMERC), and the National Supplier Clearinghouse (NSC)
- Chapter 9 (Durable Medical Equipment) - updated to reflect current information, as in the CMS Online Manual System

Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. Please follow the download instructions to print the revised pages.

Region A DMERC and PSC Affiliate Web Sites

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 our quarterly bulletins and supplier manual 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/content/psc_dmerc_reg_a.cfm***. Providers should access the PSC Web site for information on Bulletins, Fraud and Abuse, Healthcare Common Procedure Coding System (HCPCS), Medical Policies, and Progressive Corrective Action/Local Provider Education & Training (PCA/LPET). Recent updates involving medical policy development, medical review, benefit integrity, or fraud alerts can be accessed by visiting the PSC "What's New" section at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

Reminder

When accessing medical policies on the PSC Web site, providers should ensure that they are viewing the most recent revision available which is applicable for the date of service in question. Revision dates can be found under the "Revision History Explanation" section of the medical policy. The revision history is broken down by the "Revision Effective Date" and includes a description of the change(s). Current medical policies for Region A are available at ***www.tricenturion.com/content/lmrp_current_dyn.cfm***.

DMERC A ListServes

The Region A Durable Medical Equipment Regional Carrier (DMERC A) ListServes are used to notify subscribers **via email** of important and time-sensitive Medicare program information, and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DMERC A ListServes? By joining, 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 and supplier manual revisions become available on our Web site.

Additionally, there are specialty/area of interest ListServes that enable DMERC A to send targeted information to specific supplier/provider audiences, when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DMERC A ListServes gives you immediate notification of important information on Medicare changes impacting your business. Subscribe today by visiting the "ListServes" section of our Web site at ***www.umd.nycpic.com/dmlistserve.html***. Also, to receive notification of medical policy updates, subscribe to the Region A Program Safeguard Contractor (PSC) ListServe by visiting: ***www2.palmettogba.com/cgi-bin/mojo/mojo.cgi***

Changing Email Addresses

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

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

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

(**Note**: If you are subscribed to the Region A PSC ListServe as well, you will need to Unsubscribe/Subscribe in order to continue receiving medical policy update notification.)

ListServes Subscriber Form

As a convenience, the DMERC A Program Education & Training (PET) Department will subscribe you to the following ListServes. All you need to do is check the ListServe(s) you want to join and complete the information below. Fax your completed/signed form to PET at 570-735-9442.

- ❒ **Drug Coverage** - For notification of the availability of drug coverage-related information.
- ❒ **Electronic Data Interchange (EDI)** - DMERC A encourages all software vendors, billing services, and clearinghouses to join our Electronic Data Interchange (EDI) ListServe. Subscribing enables the EDI Department to notify you of important and time-sensitive electronic data interchange information as it pertains to the way you and your clients do business with DMERC A.
- ❒ **General** - For general Medicare program information and DMERC A Web site updates, and information regarding the availability of our bulletins. We encourage all suppliers/providers to join the DMERC A ListServe.
- ❒ **Mobility/Support Surfaces** - For notification of the availability of mobility/support surfaces-related information.
- ❒ **Oxygen** - For notification of the availability of oxygen-related information.
- ❒ **Parenteral/Enteral Nutrition (PEN)** - For notification of the availability of PEN-related information.
- ❒ **Prosthetics & Orthotics** - For notification of the availability of prosthetics/orthotics-related information.
- ❒ **Specialty Items** - For notification of the availability of specialty items-related information.
- ❒ **Supplier Manual** - For notification of *DMERC A Supplier Manual* revisions. We encourage all suppliers/providers to join the Supplier Manual ListServe.
- ❒ **Vision** - For notification of the availability of vision-related information.
- ❒ **Frequently Asked Questions (FAQs)** - For notification of the availability of FAQs.

*** Company Name** (please print clearly):

_____

*** Telephone Number** (please print clearly):

_____

*** Subscriber Name** (please print clearly):

_____

*** Email Address** (please print clearly):

_____

*** Signature** (grants permission to subscribe):

_____

*** This is a required field.**
(**Note**: If any of the above information is not completed, the PET Department cannot subscribe you to the ListServe(s) you have indicated on this form.)

Reminders

If the PET Department subscribes you to our ListServe(s), and you change your email address, you will need to Unsubscribe/Subscribe to the appropriate ListServe(s) as per the instructions in the "Changing Email Addresses" section.

DMERC A strives to limit our email notifications to one message a day for each ListServe account, as applicable. Therefore, you will only receive messages that are important for your business needs.

Tips for Online Bulletins

The Region A Durable Medical Equipment Regional Carrier (DMERC A) provides our quarterly bulletin in two formats on our Web site. Both contain the same information, however, they will look different when viewing and printing. One format is Web-based. The second format is Adobe's Portable Document Format (PDF), which maintains the look of printed bulletins.

To properly view PDF bulletins on the DMERC A Web site, it is strongly recommended that you download the PDF to your computer first, then open the PDF with Adobe Acrobat Reader, rather than opening it within your Web browser.

To download a PDF

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

To open a PDF

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

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

To print a PDF

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

If you select the "All" option for your print range, you can save paper by specifying odd or even page printing and print on both sides; thereby, making your printed copy look similar to a printed bulletin. If your printer cannot accommodate duplex printing, you will need to feed the paper through twice; once for the odd pages, and again for the even pages. (**Note**: Make sure you put the pages in the correct order and face them in the proper direction for printing on the reverse side).

Another way to save paper is by choosing specific pages to print, when you don't need to read or refer to the entire bulletin. This way, you will have just the pertinent information on hand when it is needed.

Coming Attractions...

The Region A Durable Medical Equipment Regional Carrier (DMERC A) posts articles and information to our Web site prior to publishing them in our bulletin. The following can be accessed via the "What's New" section at ***www.umd.nycpic.com/dme_what's_new.html***, and they will be included in our June 2005 bulletin:

- April 2005 Quarterly Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- The Centers for Medicare & Medicaid Services (CMS) Consolidation of the Claims Crossover Process
- CMS Seeks Provider Input on Satisfaction with Medicare Fee for Service Contractor Services
- Infusion Pumps: C-Peptide Levels as A Criterion for Use
- Modifications to Duplicate Editing for Dispensing/Supply Fee Codes for Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, and Inhalation Drugs
- Modified Edits for Matching Claims Data to Beneficiary Records
- News Regarding CERT
- Number of Drug Pricing Files That Must Be Maintained Online for Medicare by Durable Medical Equipment Regional Carriers (DMERCs)
- Processing Durable Medical Equipment (DME), Orthotics, Prosthetics, Drugs, and Surgical Dressings Claims for Indian Health Services (IHS) and Tribally Owned and Operated Hospitals or Hospital-Based Facilities, Including Critical Access Hospitals (CAHs)
- Prosthetics and Orthotics Ordered in a Hospital or Home Prior to a Skilled Nursing Facility Admission
- Skilled Nursing Facility (SNF) Consolidated Billing Service Furnished Under an "Arrangement" with an Outside Entity

There are also revised versions to previously published articles on skilled nursing facility consolidated billing.

Telephone Numbers

Caller Information Network	
Supplier Toll-Free Line	866-419-9458
[*TTY Hearing Impaired*	866-374-6848]
Beneficiary Toll-Free Line	1-800-MEDICARE (1-800-633-4227)
[*TTY Hearing Impaired*	1-877-486-2048]
EDI Services Help Desk	866-861-7348
Program Education & Training	570-735-9666
Program Inquiries	
Telephone Redeterminations Line	866-420-6906
Fair Hearings/ALJ Voicemail Line	866-861-7350
FAX Numbers	
Check Control/MSP	570-735-9594
Electronic Data Interchange	570-735-9510
Extra Documentation/ADMC	570-735-9402
Program Education & Training	570-735-9442
Program Inquiries (Hearings & Redeterminations)	570-735-9599
National Supplier Clearinghouse	866-238-9652
SADMERC	877-735-1326
Web Sites	www.umd.nycpic.com www.cms.hhs.gov

Addresses

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

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

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

General Correspondence
P.O. Box 1363
Wilkes-Barre, PA 18703-1363
[*for Written Inquiries, 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

Redeterminations
P.O. Box 1068
Wilkes-Barre, PA 18703-1068

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