

**Durable Medical  
Equipment Regional  
Carrier (DMERC)  
Region A**

**Supplier Notices**

**2002**

### Supplier Notice 2002-13

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: April 19, 2002

### Fee Schedule Updates

The following fee schedule updates have been posted to the DMERC Region A Web site:

- 1st Quarter Update: Oral Anti-Cancer Drug Fees
- 2nd Quarter Update: Oral Anti-Cancer Drug Fees
- 2nd Quarter Update: Drug Fees
- New Ostomy Code Fees

To access the fee schedule updates, and complete 2002 Fee Schedule, click on "Suppliers," then "Fee Schedules," at [www.umd.nypic.com](http://www.umd.nypic.com).

#### Looking For Better Ways To Serve You

In conjunction with the Centers for Medicare & Medicaid Services (CMS) initiatives, there have been recent changes to the DMERC Region A Web site; namely, an "Education" section has been added. This section features information CMS issues for publication, links to *DMERC Medicare News* articles, and information that is important for you to know. To access the Education section, click on "Education" under "Suppliers" at [www.umd.nypic.com](http://www.umd.nypic.com). Suppliers are encouraged to visit the DMERC Region A Web site for their informational needs.

The Region A DMERC ListServe is another feature on the DMERC Region A Web site. The ListServe is used to notify subscribers via email of important and time-sensitive Medicare program information, upcoming provider education and training events, and other important announcements or messages. Subscribers will also receive notice of the availability of the quarterly *DMERC Medicare News* on our Web site.

To receive reminders and announcements via email, you may join the ListServe by visiting: [www.umd.nypic.com](http://www.umd.nypic.com). Subscribe to the Region A DMERC ListServe by typing your email address in the box provided at the ListServe page.

**Supplier Notice 2002-12**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: April 12, 2002

**ATTENTION: VPIQ Users**

As of April 1, 2002, VPIQ (ViPs Provider Inquiry System) has changed as part of the HIPAA mandated 276/277 transaction sets (refer to PM AB-01-106, CR 1784). The "ALL" entry in the HICN field for options A, C, R and O is no longer a valid option. All VPIQ Users will be receiving a new User Manual within the next few weeks to reflect the changes.

If you have **not** received your new manual by May 6, 2002, please call Team EDI at 570-735-9429.

**Supplier Notice 2002-11**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: March 28, 2002

**ATTENTION: ACCELERATE USERS**

Effective April 1, 2002, per Change Request 1612, suppliers must file claims for blood glucose supplies and test strips on behalf of the beneficiary for dates of services on or after **April 1, 2002**. Medicare will no longer accept claims filed by the beneficiary for date of service on or after April 1, 2002. Suppliers must also complete the "from" and "to" dates in Block 24 of the HCFA-1500 form when filing claims for blood glucose supplies (codes A4253, A4255, A4256 and A4259). The "from" and "to" dates cannot be exact duplicates.

Accelerate users will not be able to span dates with a number of service as 1. Accelerate users who are billing number of service as 1 will need to use the same from and to date and put the following information in the HA0 record:

User of Accelerate software, the correct date span  
ex: "User of Accelerate software DOS 4-1-02 through 4-30-02."

If the above information is not contained in the HA0 record your claims will be denied.

**Supplier Notice 2002-10**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: March 27, 2002

**Billing Reminder: Ostomy Supplies**

As referenced in the local medical review policy (LMRP) # 16.10 for Ostomy Supplies, under documentation requirements:

"The supplier must enter the diagnosis code for the ostomy on **each claim** submitted for ostomy supplies. If more than one ostomy, enter the appropriate codes."

Without the above information, claims may be denied.

**Supplier Notice 2002-09**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: March 27, 2002

**Oxygen Coverage for Beneficiaries Previously Enrolled In Managed Care Who  
Transition to Traditional Fee For Service (FFS)**

When a beneficiary who was on oxygen in a Medicare HMO transitions to traditional FFS Medicare, an Initial Certification of Medical Necessity (CMN) must be completed and submitted to the DMERC in order for FFS coverage to begin. According to a recent decision announced by the Centers for Medicare & Medicaid Services (CMS), the blood gas study reported on the CMN does not have to be obtained within 30 days prior to the Initial Certification date, but the blood gas study must be the most recent study the patient obtained while in the HMO, under the guidelines specified in DMERC policy. However, this policy becomes effective only for claims (initial determinations or appeals) processed by the DMERC on or after July 1, 2002. For claims processed on or after July 1, 2002, it applies to all dates of service including those prior to July 1, 2002. Due to current system limitations, for claims submitted prior to July 1, 2002, Region A is offering two options to the provider community:

1. If submitting claims prior to July 1, 2002, the provider must indicate in the HAO record or on the claim "Oxygen-HMO transfer to FFS beneficiary". Without this indication, the claim may be denied, due to system restrictions.
2. The provider may hold Oxygen claims until July 1, 2002 for patients who were previously enrolled in Medicare Managed Care (HMO) and are now on Traditional Medicare Fee-For-Service (FFS).

**Supplier Notice 2002-08**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: February 25, 2002

**Telephone Adjustment Requests**

Effective March 1, 2002, the Region A DMERC will no longer accept any telephone requests to adjust a claim via the Caller Information Network or the Program Education and Training Telephone Lines. We are discontinuing this practice to prepare for the introduction of our Telephone Review services in the future.

Any adjustment requests received prior to March 1, 2002 will continue to be processed.

If you do not agree with a claim determination, you can file a written review request to:

HealthNow DMERC Region A  
Attn: Program Inquiries Department  
P.O. Box 6300  
Wilkes-Barre, PA 18773-6300

**Supplier Notice 2002-07**

To: DMERC Region A Supplier Community  
 From: DMERC Region A  
 Date: February 22, 2002

**Revised Timelines for Health Insurance Portability and Accountability Act  
 (HIPAA) Requirements**

As per Change Request 2039 issued by the Centers for Medicare & Medicaid Services (CMS) on February 8, 2002, the following dates are now effective for implementation of the HIPAA transaction sets noted below. Any entity, referred to as a "trading partner" below (including COB trading partners and electronic submitters), that submits electronic claims to a Medicare Carrier, must be compliant with these HIPAA transaction standards by October 16, 2002. If a trading partner is not prepared to submit compliant transactions by this date, the trading partner must apply to the Department of Health and Human Services (HHS) for an extension of HIPAA compliance dates. This request must include the trading partner's plan to achieve compliance on or before October 16, 2003. Refer to H.R. 3323, Section 3 for additional information.

**Schedule for HIPAA Mandated ANSI Transaction Sets**

<b>Transaction Set</b>	<b>Testing to Begin</b>	<b>Testing Completion Date</b>
X12N 837 In-bound Claims	April 16, 2002	October 16, 2002 *
X12N 835 Elec. Remit. Not.	May 16, 2002	October 16, 2002 *
X12N 837 COB Claims	June 17, 2002	October 16, 2002 *
X12N 276/277 Claims Status	July 1, 2002 (testing provided by request only)	
X12N 270/271 Eligibility	Instruction pending	

**OR BEFORE OCTOBER 16, 2003 IF AN EXTENSION IS REQUESTED.**

**Medicare Free Billing Software**

Medicare free billing software for HIPAA compliant ANSI transactions is scheduled to be available for distribution to providers/billers by December 3, 2002. CMS intends to eliminate free software effective fiscal year 2004 (October 2003 through September 2004).

Users of Medicare free billing software (including Accelerate) must request an extension from the Department of Health Human Services in order to continue to use this software between October 16, 2002 and December 3, 2002.

**Supplier Notice 2002-06**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: January 22, 2002

**2002 Cap Fees for Therapeutic Shoes**

Listed below is the listing of 2002 Special Limitations for Therapeutic Shoes under the Standard Reasonable Charge Rules. These limits apply to codes **A5500 - A5506 and A5509 - A5511**. Reasonable charge fees are established for each state. However, the maximum allowable amount for each code cannot exceed the cap amount. The current cap breakdown for 2002, which is the same for all states, is as follows:

<b>Code</b>	<b>Ceiling</b>
A5500	\$66.00
A5501	\$197.00
A5502	\$33.00
A5503	\$33.00
A5504	\$33.00
A5505	\$33.00
A5506	\$33.00
A5509	\$33.00
A5510	\$33.00
A5511	\$33.00

**Supplier Notice 2002-05**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: January 18, 2002

**Revision to Supplier Notice 2001-30 ANSI X12N 837 Professional Health Care Claim Companion Document**

*This notice serves as a revision to the previously issued Supplier Notice 2001-30, "ANSI X12N 837 Professional Health Care Claim Companion Document," dated November 21, 2001. All information as published in Supplier Notice 2001-30 remains applicable. The information in bold type was inadvertently omitted in the original notice.*

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N 837 implementation guides have been established as the standards of compliance for claim transactions. The implementation guides for each transaction are available electronically at [www.wpc-edi.com](http://www.wpc-edi.com)

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 837 implementation guides. The use of this document is solely for the purpose of clarification.

The information describes specific requirements to be used for processing data in the ViPS Medicare System, VMS, of HealthNow New York Inc. Region A DMERC, Contractor number, 00811. The information in this document is subject to change. Changes will be communicated in the standard "DMERC Medicare News" quarterly news bulletin and on HealthNow New York Inc.'s Web site: [www.umd.nycpic.com](http://www.umd.nycpic.com). This companion document supplements, but does not contradict any requirements in the X12N 837 Professional implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

**LANGUAGE**

- Negative values submitted in the following fields will not be processed and will result in the claim being rejected: Total Claim Charge Amount (2300 Loop, CLM02), Patient Amount Paid (2300 Loop, AMT02), Patient Weight (2300 and 2400 Loop, CR102), Transport Distance (2300 and 2400 Loop, CR106), Payer Paid Amount (2320 Loop, AMT02), Allowed Amount (2320 Loop, AMT02), Line Item Charge Amount (2400 Loop, SV102), Service Unit Count (2400 Loop, SV104), Total Purchased Service Amount (2300 Loop, AMT02), and Purchased Service Charge Amount (2400 Loop, PS102).
- The only valid values for CLM05-3 (Claim Frequency Type Code) are '1' (ORIGINAL) and '7' (REPLACEMENT). Claims with a value of '7' will be processed as original claims and will result in duplicate claim rejection. The claims processing system does not process electronic replacements.
- The maximum number of characters to be submitted in the dollar amount field is seven characters. Claims in excess of 99,999.99 will be rejected.
- Claims that contain percentage amounts submitted with values in excess of 99.99 will be rejected.
- Claims that contain percentage amounts submitted with more than two positions to the left or the right of the decimal will be rejected.
- Data submitted in CLM20 (Delay Reason Code) will not be used for processing.

- HealthNow New York Inc. Region A DMERC will convert all lower case characters submitted on an inbound 837 file to upper case when sending data to the Medicare processing system. Consequently, data later submitted for coordination of benefits will be submitted in upper case.
- You must submit incoming 837 claim data using the basic character set as defined in Appendix A of the 837 Professional Implementation Guide. In addition to the basic character set, you may choose to submit lower case characters and the '@' symbol from the extended character set. Any other characters submitted from the extended character set will cause the interchange (transmission) to be rejected at the carrier translator.
- The subscriber hierarchical level (HL segment) must be in order from one, by one (+1) and must be numeric.
- Currency code (CUR02) must equal 'USA'.
- **Diagnosis codes have a maximum size of five (5). Medicare does not accept decimal points in diagnosis codes.**
- Total submitted charges (CLM02) must equal the sum of the line item charge amounts (SV102).
- Do not use Credit/Debit card information to bill Medicare (2300 loop, AMT01=MA and 2010BD loop).
- Service unit counts (units or minutes) cannot exceed 999.9 (SV104).
- For Medicare, the subscriber is always the same as the patient (SBR02=18, SBR09=MB). The Patient Hierarchical Level (2000C loop) is not used.
- Only loops, segments, and data elements valid for the HIPAA Institutional or Professional Implementation Guides will be translated. Non-implementation guide data may not be sent for processing consideration.
- Any data submitted in the PWK (Paperwork) segment may not be considered for processing.
- All dates that are submitted on an incoming 837 claim transaction should be valid calendar dates in the appropriate format based on the respective qualifier. Failure to submit a valid calendar date will result in rejection of the claim or the applicable interchange (transmission).
- HealthNow New York Inc. Region A DMERC will edit data submitted within the envelope segments (ISA, GS, ST, SE, GE, and IEA) beyond the requirements defined in the Institutional or Professional Implementation Guides. Invalid header and trailer segments (ISA, GS, ST, SE, GE and/or IEA) could result in an unexpected outcome during translation.
- HealthNow New York Inc. Region A DMERC may reject an interchange (transmission) that is not submitted with unique values in the ST02 (Transaction Set Control Number) elements.
- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) that is not submitted with a valid carrier code. Each individual Contractor determines this code.
- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) submitted with more than 9,999 loops.
- HealthNow New York Inc. will reject an interchange (transmission) submitted with more than 9,999 segments per loop.

- HealthNow New York Inc. Region A DMERC will reject an interchange (transmission) with more than 5,000 CLM segments (claims) submitted per transaction.
- You may send up to eight diagnosis codes per claim; however, the last four diagnosis codes will not be considered in processing.
- Only valid qualifiers for Medicare should be submitted on incoming 837 claim transactions. Any qualifiers submitted for Medicare processing not defined for use in Medicare billing will cause the claim or the transaction to be rejected.
- You may send up to four modifiers; however, the last modifier may not be considered.
- HealthNow New York Inc. Region A DMERC will return the first 6-digits of the inbound version as the version in GS08 (Version/Release/Industry Identifier Code) of the 997.
- We suggest retrieval of the ANSI 997 functional acknowledgment files on the first business day after the claim file is submitted, but no later than five days after the file submission.
- Compression of files using the .zip format is supported for transmissions between the submitter and HealthNow New York Inc. Region A DMERC.

**Supplier Notice 2002-04**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: January 18, 2002

**1st Quarter Update: Drug Fees**

The **Updated Drug Fees for the 1st quarter of 2002** are now available on the DMERC Region A Web site.

To access this information on our Web site:

- Visit **www.umd.nycpic.com**.
- Click on the DMERC Region A logo.
- Under **Suppliers**, click on **Fee Schedules**.
- On the Fee Schedules page, click on **1st Quarter Update: Drug Fees**.

**Supplier Notice 2002-03**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: January 10, 2002

**Attention ProComm Connections 4.6 Users**

As we informed you in Supplier Notice 2001-28 ("Bulletin Board Equipment Move"), the DMERC Region A will be moving the Bulletin Board Systems telecommunications equipment to its home office in Binghamton, NY. Because of this move, you must change to the new dial-in telephone numbers for both claims submissions and retrieval of electronic remittance notices through the Bulletin Board Systems.

**To Change the Dial-in Number for the DMERC Region A Claims Submission Bulletin Board System (as of January 22, 2002):**

1. Click on **Start**.
2. Go to **Programs**.
3. Go to **Procomm Plus**.
4. Go to **Procomm Plus** again. Clicking this will launch ProComm. Once it has opened you will see Procomm Plus Ready.
5. Click **File**, and then click on **Connection Directory**.
6. Select the Medicare Entry from the list.
7. Change the Area Code to: 607.
8. Change the Data Number to: 766-6349.
9. Click **OK**. You may now proceed as normal.

**To Change the Dial-in Number for the DMERC Region A Remittance Bulletin Board System (as of January 22, 2002):**

1. Click on **Start**.
2. Go to **Programs**.
3. Go to **Procomm Plus**.
4. Go to **Procomm Plus** again. Clicking this will launch Procomm. Once it has opened, you will see Procomm Plus Ready.
5. Click **File**, then click on **Connection Directory**.
6. Select the ERN Entry from the list.
7. Change the Area Code to: 607.
8. Change the Data Number to: 766-6409.
9. Click **OK**. You may now proceed as normal.

**Supplier Notice 2002-02**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: January 9, 2002

**2002 Fee Schedule Available on Our Web Site**

**Thursday, January 10, 2002**

The 2002 Fee Schedule will be available on our Web site on Thursday, January 10, 2002. You can access the 2002 Fee Schedule by following these steps:

Access our Web site at **[www.umd.nycpic.com](http://www.umd.nycpic.com)**  
Click on the **DMERC** side.  
Click on the **Fee Schedules** option under **Suppliers**.

**Supplier Notice 2002-01**

To: DMERC Region A Supplier Community  
From: DMERC Region A  
Date: January 4, 2002

**Attention: All Electronic Submitters**

This is a reminder that the Bulletin Board System is moving to our home office in Binghamton, NY the weekend of January 19, 20 and 21, 2002.

Our Bulletin Board System will be unavailable to accept claims submissions or retrieve electronic remittance notices from 6:00 PM Friday, January 18, 2002 through 8:00 AM Tuesday, January 22, 2002.

The phone numbers for the Bulletin Board Systems have also changed as of January 22, 2002. The new numbers are:

Claims submission:	607-766-6349
Electronic remittance retrieval:	607-766-6409

Please change these phone numbers in your communications software as of January 22, 2002.