under Part A or Part B as a Medicare “provider of services,” and is billing under an appropriate provider of services number, it is not affected by this revision. However, if an entity operates a home health agency or a skilled nursing facility is furnishing services as a Medicare “supplier,” then that entity must comply with the revised manual instructions. That is, a licensed pharmacy with a Medicare supplier number must bill for the prescription drug.

16. The supplier media is full of articles about ways to comply with this new requirement. One of the most common, aside from purchasing a licensed pharmacy, is to have the supplier act as a billing agent for the pharmacy. Is this an acceptable arrangement? What constraints might apply?

Yes, a supplier may act as a billing agent for a licensed pharmacy dispensing prescription drugs. However, the supplier/billing agent must comply with the requirements in section 3060.D of the Medicare Carriers Manual on payment to agent. One of the requirements in 3060.D states the billing agent is not paid on a percentage basis of the dollar amounts billed or collected. If the billing agent is paid on some other basis, then the check made out in the name of the pharmacy must be deposited in the pharmacy’s bank account, and the pharmacy must have sole control of the funds. Thus, the supplier may not cash the check made out in the name of the pharmacy.

In addition, the billing agent’s compensation must be commensurate with the market value for billing services in the area. Under acceptable billing arrangements, all claims must be submitted under the pharmacy’s supplier number.

17. Will the new pharmacy providers have to conform to all HCFA standards that are now required of DME providers?

Yes. In order to receive a Medicare supplier number a pharmacy must comply with the DME standards.

18. If a pharmacy purchases medications from another pharmacy, which may be located in another state, can the first pharmacy bill Medicare for the medication dispensing fee?

Regardless of the chain of acquisition through which the drugs come, it is only the pharmacy that ultimately dispenses the drug to the beneficiary which is allowed to bill the Medicare program for the drugs and dispensing fee.

19. Are there any related Medicare restrictions that apply to saline used to dilute nebulizer drugs?

Yes. Nebulizer drugs dispensed to patients in concentrated form require dilution with precise amounts of saline. The quantities of saline dispensed for this purpose, instructions for its proper use and monitoring of utilization to assure compliance with the physician’s prescription are all necessary functions of any dispensing pharmacist. Because saline used as a diluent is an intrinsic component of the inhaled form of a concentrated nebulizer drug, it may only be dispensed and billed to the Medicare program by a licensed pharmacist.
Effective January 1, 1997, Palmetto Government Benefits Administrators (Palmetto GBA) will be mailing checks to suppliers in envelopes marked “Do Not Forward.” Suppliers with new addresses who have not submitted a change of address to the National Supplier Clearinghouse (NSC) may not receive payments from the DMERC unless address corrections are received and processed. All address changes must be submitted to the NSC. A change of address form may be found on page 1.10 of the DMEPOS Supplier Manual. Submit all address changes to the National Supplier Clearinghouse, P.O. Box 100142, Columbia, S.C. 29202-3142.

Suppliers receiving payment via electronic funds transfer (EFT) will not be impacted by this change.

Any services provided by a supplier prior to the effective date of the supplier number issued by the National Supplier Clearinghouse may not be paid by the Durable Medical Equipment Regional Carriers (DMERCs). The date the NSC issues a supplier number to a new supplier will determine the effective date for billing Medicare. Services provided by a supplier prior to the effective date of the supplier number issuance will be denied.

HCFA had previously extended until June 30, 1996, the timely filing period for the End Stage Renal Disease, Medicare Secondary Payer provision of the Omnibus Reconciliation Act 1994 (OBRA 1993) for claims with services provided between August 10 and September 30, 1993. (See April 1996 DMERC Medicare Advisory, page 96-175).

Because of the need for efficient program administration, HCFA has determined its final filing date to be April 1, 1997. Effective this date, HCFA will no longer pay claims relative to past COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) situations that are not for services furnished within the normal 15-27 month Medicare claims filing period.
♦ DMERC Medical Policy Correction: On page 96-306 of the September 1996 DMERC Medicare Advisory, the Lymphedema Pump documentation article contained an error. The following sentence should read, "A simple diagnosis code on the claim or CMN rarely will explain adequately such a resultant condition." The acronym "HCPCS" was inserted in error.

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HCFA has clarified which carrier has jurisdiction over items and services according to their HCPCS codes. The most current chart can be found in the enclosed December 1996 DMEPOS Supplier Manual Revisions, and should enable you to determine whether claims are submitted to your local carrier or to your DMERC. It supersedes any prior publication of the jurisdiction of services.

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Excluded Providers

Effective immediately, a revised process is to be followed when the DMERC receives a claim from a supplier for items ordered at the medical direction of, or prescribed by, an excluded provider.

Palmetto GBA, as well as all durable medical equipment carriers, are to pay the first claim received, give notice of the physician exclusion to the supplier and the beneficiary, and only pay claims for items/services furnished within 15 days following the date of the notice. Only one notice will be furnished per supplier, and the supplier has only a 15-day window to submit claims for items ordered, prescribed or referred by an excluded physician.

The Medicare Carriers Manual section 14030.10 will be updated to reflect this new procedure in the near future.
In an effort by the HCFA to promote a clear awareness and understanding of what information suppliers may provide on Certificate of Medical Necessity (CMN) forms, suppliers are limited to providing the following information on the forms to the physician:

- The identification of the supplier and the Medicare beneficiary to whom such medical equipment and supplies are furnished;
- A description of such medical equipment and supplies;
- Any product code identifying such medical equipment and supplies;
- The fee schedule amount and the supplier’s charge for the medical equipment or supplies being furnished; and
- Any other administrative information, other than information relating to the beneficiary’s medical condition, identified by the Secretary. (Please note that the supplier **may not** complete Section B of the CMN).

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**Hearing Requests**

Below are some helpful suggestions to ensure expedient and efficient processing of your hearing request(s).

- A review must be completed on the claim in question prior to the hearing request. The only exception is for overpayments greater than $100. If the request for overpayment is more than $100, a review is not required. However, a copy of the overpayment letter must be attached to the hearing request.

- Provide all necessary information pertinent to the hearing request:

<table>
<thead>
<tr>
<th>Beneficiary’s name</th>
<th>Date(s) of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>HICN number</td>
<td>Claim control number</td>
</tr>
<tr>
<td>Supplier number</td>
<td>Document control number</td>
</tr>
</tbody>
</table>

(The review letter contains all of this information.)

- Be sure to direct hearing requests to the appropriate DMERC or Medicare carrier, i.e. the carrier who conducted the review.

- Specify the type of hearing on the request, i.e. on the record, telephone or in person.

- The amount in controversy must be at least $100. A single hearing request can be made on multiple claims to meet the $100 minimum requirement.

- A supplier cannot request a hearing on a non-assigned claim.

- When multiple patients or claims are combined in one hearing request, your request may take longer to process.
Electronic Data Interchange (EDI) Update

PACES software

PACES includes:

- contractor-maintained basic front-end edits;
- minimal effort for software installation and training by submitters;
- clear and understandable software documentation, with assistance readily available; and
- the ability to prepare and send HCFA-approved EMC forms or attachments as they are developed and approved.

Palmetto GBA EDI maintains and offers, upon request, a comprehensive Certified Vendor List for those submitters who require a more comprehensive software package to service their business needs. To receive this list, call the EDI Help Line at (803) 788-9751.

Data formats

Effective July 1, 1996, the DMERC began accepting electronic media claims (EMC) only if submitted in the NSF version 2.0 or the ANSI ASC X12 837 formats. Electronic remittance notices (ERN) are generated in either the NSF 2.0 or the ANSI ASC X12 835 formats. For a copy of the NSF and Palmetto GBA specifications for ANSI ASC X12 837 or 835 Implementation Guides, contact the EDI Help Line at (803) 788-9751.

For asynchronous communications, Palmetto GBA accepts the ANSI ASC X12 837 as a continuous byte stream or as a variable length record. Palmetto GBA accepts the NSF in 320 byte records and does not require the data to be broken down into 80 byte segments or any other deviation from the variable length format or the continuous byte stream format. Medicare flat files are self-enveloped and the envelope provided should be the only one used.

Effective October 1, 1996, Palmetto GBA will supply, upon request, the Functional Acknowledgment Standard Format to all requesting providers in response to flat file submission. Effective December 1, 1998, the ANSI X12 997 Functional Acknowledgment and the flat file Functional Acknowledgment will be the only acceptable formats generated for providers upon their request.

Effective October 1, 1998, electronic claims received via fax/optical character recognition, diskette or touch-tone phone will be utilizing the payment floor of 27 days. Currently a payment floor of 14 days is applied to electronic claims.

Providers submitting their claims electronically are encouraged to choose among options such as Palmetto GBA's PACES software for
EDI UPDATE
(continued)

Data confidentiality

It is necessary to remind electronic billing services, clearinghouses and network services that all Medicare beneficiary-specific information is confidential and subject to the requirements of Section 1106 (a) of the Social Security Act and implementing regulations at 42 C.F.R. Part 401, Subpart B. Those regulations specify that, as a general rule, every proposed disclosure of Medicare information shall be subject to the Freedom of Information Act rules at 45 C.F.R. Part 5. All such information, to the extent that it is maintained in a "system of records," is protected under the provisions of the Privacy Act of 1974 (5 U.S.C. 552a). Remittance advice, eligibility information, online claims corrections and any other transactions involving medical information may not be disclosed to anyone other than the provider, supplier or beneficiary for whom the claim was filed.

DMERC CERTIFIED SOFTWARE VENDORS, BILLING SERVICES AND CLEARINGHOUSES

Current list now available

Palmetto GBA, Electronic Data Interchange (EDI), maintains a list of software vendors, billing services and clearinghouses that have demonstrated the ability to submit electronic claims for durable medical equipment, prosthetics, orthotics and supplies in the National Standard Format (NSF). These companies have been certified by the DMERC.

To obtain a copy of the list in its entirety, contact the EDI Help Line.

EDI Help-Line (803) 788-9751

NOTE: When contacting any software vendor, billing service or clearinghouse, please confirm they can transmit claims in NSF 2.0. Effective, August 1, 1996, Palmetto GBA will not accept claims which are not in NSF 2.0.

INFORMATION AVAILABLE ON-LINE

How to access pending and resolved claims

Claims Status Inquiry (CSI) is an on-line transaction enabling electronic submitters to access a six-month history of their pending and resolved claims. It displays data for assigned and non-assigned claims; however, CSI displays pending information, but no payment amounts for non-assigned claims.

If you wish to enroll for CSI, you must complete an enrollment form. Billing services and clearinghouses must have their suppliers complete an additional form authorizing CSI access by a third-party. Corporate offices who have branches with individual supplier numbers should complete the CSI Addendum for corporate offices. To request these forms, or to order CSI software, contact the EDI Help Line.
NOTE: Palmetto GBA offers ProComm and Passport/Advantis software and customized scripts to perform CSI. All you need is a DOS-based PC and a modem. Your software vendor also may offer CSI capabilities; Palmetto GBA suggests you check with your vendor before ordering software.

How to access publications

The Bulletin Board System (BBS) contains a library of Medicare information such as DMERC Medicare Advisories, supplier manuals, procedure codes, diagnosis codes and fee schedules. The BBS can even be used to transmit Medicare claims and to retrieve claim reports. To use the BBS, all you need is a PC and:

- A Hayes compatible modem (2400–14.4 baud rate),
- Communications software (other than Kermit), and
- PKZIP/PKUNZIP compression utility (Version 2.04G) to download compressed files from the BBS. PKZIP/PKUNZIP can be downloaded from the Palmetto GBA BBS.

There are two types of BBS users: the general user and the certified user:

General users download reference materials such as Electronic Data Interchange (EDI) order forms, EDI software manuals, DMERC Medicare Advisories and DMERC supplier manuals. There are no enrollment forms to become a general user. Simply follow the LOG ON procedures below. Once you have accessed the BBS, you may download available files.

**BBS general user log on procedures**

Dial the Palmetto GBA BBS at (803) 788-1403 through your modem. After connecting, you will see the following messages:

1. What is your name?
   Type GUEST1. Use GUEST2 or GUEST3 if GUEST1 is busy.
2. GUEST1 [Y, N]?
   If this is correct, press <Enter>. If not, type N, press <Enter> and reenter your log-on name correctly.
3. Password
   Type PGBA

Certified users can transmit claims and retrieve edit reports and Electronic Remittance Notices (ERNs) from the BBS. If you choose the BBS in addition to the options available to a general user for retrieval of reports and/or ERNs, they will no longer be available from your electronic mailbox. To become a BBS certified user you must:

- Already be qualified to send claims electronically to Palmetto GBA.
- Complete and return the BBS Enrollment Form and User Disclaimer. These forms are available by calling the EDI Help Line at (803) 788-9751.