SALES TAX

Sales tax, if billed separately, is non-covered by Medicare. Sales tax may be billed using HCPCS code A9270.

BILLING REMINDER

This a reminder to suppliers that claims for durable medical equipment, prosthetics, orthotics and supplies may not be submitted to Medicare prior to the item(s) being supplied or provided. Suppliers found to be billing for services before they are provided will be referred for investigation.

RECERTIFICATION

Recently, Palmetto GBA began notifying suppliers when recertification is due for their patients. Suppliers are reminded to submit the recertification with the appropriate claim(s) and not separately.

POV REPAIRS

As a reminder to suppliers, the following information is required on all power operated vehicle (POV) repair claims.

♦ statement indicating the beneficiary owns the equipment;

♦ equipment's make and model;

♦ itemization of all parts, including manufacturer part numbers and price of all parts;

♦ use of HCPCS code E1399 (DME, miscellaneous) and modifier RP (replacement part) if no specific HCPCS code is available; and

♦ If rental equipment is necessary while patient owned equipment is being repaired, a supplier must bill the rental POV as HCPCS E1399RR, showing on the hard copy claim or in the HAØ record that this equipment is being rented while patient owned equipment is being repaired.

PLACE OF SERVICE REMINDER

As a reminder to the supplier community, claims received for refractive lenses are not to be billed with place of service 11 (physician's office). Place of service on claims for lenses, frames or contact lenses should be submitted indicating the patient's residence as the place of service. Claims received with place of service 11 will be denied.
MEDICARE SECONDARY PAYER

Medicare Secondary Payer involves all benefits for which Medicare may be secondary. This includes working aged, end stage renal disease (ESRD), Black Lung, disability, workers’ compensation and liability. Chapters 1 and 9 of the Region C DMEPOS Supplier Manual explain the MSP process and the procedures to be used when filing claims to Medicare for secondary benefits. Claims should be submitted to the designated team address specified in Chapter 10 of the Region C DMEPOS Supplier Manual, but all MSP correspondence should now be directed to:

Palmetto Government Benefits Administrators
Medicare Secondary Payer Team-Y
P.O. Box 100209
Columbia, S.C. 29202-3209

This address is for correspondence only.

The documentation required when submitting claims for secondary benefits should always include the HCFA-1500 (12/90) form and a copy of the explanation of benefits (EOB) from the primary payer. The HCFA-1500 (12/90) claim form should always be completed showing total charges, just as the claim was submitted to the primary payer. Reductions should not be applied as a result of any primary payments.

Effective September 1, 1997, Palmetto GBA will no longer be able to accept the certificate of medical necessity denial for Black Lung benefits, unless the product ordered is denied with definitive language that explains why the item is non-covered by the Black Lung benefit. This is a HCFA requirement for payment consideration by the Medicare program for any potentially covered product or service.

Effective September 1, 1997, Palmetto GBA will also require an EOB rather than a letter for patients whose primary insurance does not provide benefits for durable medical equipment. Each claim submitted for payment must be accompanied by an EOB, even though the patient’s policy has no durable medical equip-

ZZ001-ZZ011 BILLING

HCPCS codes ZZ001-ZZ011 were designed to allow suppliers to bill for denial of non-covered equipment, accessories or supplies. The exception is HCPCS code ZZ010 (transtracheal oxygen catheter for patient-owned equipment), which is covered and payable for patient-owned equipment.

For a complete listing of these codes, see page A.37 of the Region C DMEPOS Supplier Manual.
**DISCOUNT BILLING**

When billing a discount for an item on a HCFA-1500 (12/90) claim form submitted to Palmetto GBA, the discount is to be billed on the appropriate equipment or supply line item of the form. The discount is not to be billed separately and/or reduced from the total amount of the claim.

Example: [section 24 of the HCFA-1500 (12/90) form]

Apply a 20 percent discount on HCPCS code E0607 (blood glucose monitor) at $100, HCPCS code A4259 (lancets) at $15 each and HCPCS code A42536 (test strips) at $50 each.

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**WHEELCHAIR CUSHIONS BILLING REMINDER**

When billing for HCPCS code E0192, low pressure and positioning equalization pad, information should be included on the claim form or in the HAØ record to indicate whether the patient owns a wheelchair. Claims submitted for code E0192 without this information may be denied.
ELECTRONIC CROSSOVER SERVICES

Participating suppliers can avoid filing Medigap claims by taking advantage of Palmetto Government Benefits Administrators' electronic crossover services. The Medigap crossover process eliminates the need for beneficiaries or participating suppliers to file separate claims to Medigap insurers. Palmetto GBA will automatically transmit claim information to Medigap insurers at the end of each month when the beneficiary elects to assign their Medigap benefits to a participating provider.

Medigap policies

A Medigap policy must meet the statutory definition of a "Medicare supplemental policy" contained in Section 1882(g)(1) of Title XVIII of the Social Security Act. It is a health insurance or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Palmetto GBA's remittance notice will contain a remark code, MA18, that will identify each Medicare claim that Palmetto GBA has forwarded to a Medigap Insurer. There will not be a "forwarded to" line for the beneficiary when claim information is forwarded by the Medigap process. To ensure Palmetto GBA has the necessary information to effect this Medigap crossover, participating suppliers should adhere to the HCFA-1500 (12/90) form filing instructions below. The information must be completed to permit automatic crossover of claims to Medigap insurers. If this required information is missing or incomplete, transfer of claim information will not occur.

Item 9: Enter the last name, first name and middle initial of the enrollee in the Medigap policy, if it is different from that shown in Item 2 [of the HCFA-1500 (12/90 form). Otherwise, enter the word SAME. If the Medigap benefits are not assigned, leave blank.

NOTE: Participating suppliers are to complete Item 9 and its subdivisions only when the beneficiary wishes to assign his or her benefits under a Medigap policy to the participating supplier.

Item 9a: Enter the word "MEDIGAP" followed by the policy and/or group number of the Medigap enrollee.

Item 9b: Enter the Medigap enrollee's birth date and sex.

Item 9c: Enter the claims processing address for the Medigap Insurer.
Item 9d: Enter the name of the Medigap enrollee’s insurance company.

NOTE: Participating suppliers may place the OCNA number rather than the name of the insurance company in Item 9d and omit the completion of Item 9c.

Complementary/supplemental policies

Non-Medigap Medicare supplemental policies are Medicare supplement policies that do not meet the definition of “Medigap” policies. Often these policies are referred to as “complementary coverage” policies.

Medicare rules do not permit automatic crossover of the Non-Medigap Medicare supplemental policy to the insuring organization. Rather, the non-Medigap Medicare supplemental insurer can voluntarily elect to enter into an agreement with Medicare for automatic crossover of Medicare claims information for their policyholders. At the end of this article appears a list of those insurers who have agreements with Palmetto GBA.

Do not list these Non-Medigap Medicare supplemental policies under Item 9 of the HCFA-1500(12/90) form. If Palmetto GBA has an agreement with a Non-Medigap Medicare Supplemental Insurer, Medicare claim information is automatically forwarded to that insurer, and a supplier’s Medicare remittance will indicate such action.

The supplemental insurers and South Carolina Medicaid send eligibility files to Palmetto GBA containing their beneficiaries’ Medicare numbers and dates of eligibility. If claim dates of service and Medicare numbers match dates of eligibility and Medicare numbers on the file from the Supplemental insurer or Medicaid, Palmetto GBA will automatically forward the Medicare claim information to that insurer or Medicaid. This information is transferred at the end of the week in which the claim comes off the payment floor. If a beneficiary has coverage with more than one supplemental insurer and each insurer includes the beneficiary’s Medicare number on their eligibility file, the claim will be forwarded to each supplemental insurer. However, if a beneficiary has supplemental insurance and is eligible for Medicaid, the claim information will not be forwarded to Medicaid.

When a claim is forwarded to a supplemental insurer, a supplier’s remittance will contain a remark code MA18. The name of the company to which the claim was forwarded will be on the “forwarded to” line for the beneficiary. If the beneficiary is covered by Medicaid, a suppliers’ remittance will contain a remark code MA07. There will be no “forwarded to” line for the beneficiary when claim information is forwarded to Medicaid.
Insurers who have agreements with Palmetto GBA include:

- Acordia Senior Benefits, Inc.
- Acordia Senior of the SE, Inc.
- Aetna Life Insurance Co.
- Alabama Medicaid
- American Family Life Assurance (AFLAC)
- American Postal Workers
- American Republic Insurance
- Arkansas Medicaid
- BCBS of Alabama
- BCBS of Arkansas
- BCBS of Colorado
- BCBS of Florida
- BCBS of Louisiana
- BCBS of Michigan
- BCBS of New Mexico
- BCBS of North Carolina
- BCBS of Oklahoma
- BCBS of South Carolina (over 65)
- BCBS of South Carolina (FEP)
- BCBS of Texas
- BCBS of Wisconsin
- Central States Health & Life Claims Administration Corp. (Mailhandlers)
- Colorado Medicaid
- Dallas General Life Ins.
- Empire BCBS
- Florida Medicaid
- Georgia Medicaid
- Government Employee Hospital Assoc.
- Group Health Inc. (GHI)
- Humana Health Plan
- Kentucky Medicaid
- Kirke-Van Orsdel, Inc.
- Louisiana Medicaid
- Metrahealth (United Healthcare)
- Mississippi Medicaid
- Mutual of Omaha
- National Assoc. of Letter Carriers
- New Mexico Medicaid
- North American Insurance Co.
- North Carolina Medicaid
- Oklahoma Medicaid
- Olympic Health Management
- Physicians Mutual Ins.
- Pioneer Life Insurance
- South Carolina Medicaid
- Standard Life and Accident
- Tennessee Medicaid
- Texas Medicaid
- The Prudential Ins (AARP)
- Triple-S (Seguros de Servicio de Salud de Puerto Rico)
- Union Fidelity Life Insurance
- United American Insurance
- USAA Life Insurance
**Electronic Data Interchange (EDI)**

**Enrollment form**

The Health Care Financing Administration has mandated all suppliers submitting electronic claims to the DMERC(s) have a current and valid Electronic Data Interchange Enrollment on file with the DMERC(s). HCFA states "each new EMC biller must sign the HCFA standard EDI Enrollment Form and submit it to you (the DMERC) before you (the DMERC) accept the first claim from that biller."

This means that a current and valid EDI Enrollment must be on file at whichever DMERC ultimately receives an electronic claim for adjudication. For example, if a supplier submits a claim(s) to Region B and it is transferred to Region C for adjudication because the beneficiary resides within Region C, the supplier must have a current and valid EDI Enrollment on file with Region C.

Whether claims are sent directly to Region C or transferred from another DMERC to Region C, a current and valid EDI Enrollment must be on file with Region C. Suppliers who do not have a current and valid EDI Enrollment on file will receive front-end rejects with an "error number 678" on any and all claims submitted.

Suppliers are to ensure they have a current and valid EDI Enrollment on file with every DMERC to which claims may be sent for adjudication, whether directly or via transfer from one DMERC to another. For more information, contact the Palmetto GBA EDI Help Line at (803) 788-9751.

**HCFA Internet Homepage**

Medicare EDI publications and materials are now available on the Internet. The Health Care Financing Administration Standards Setting Unit has published these materials on the HCFA Internet Homepage, to include facts about Medicare EDI, advantages to using EDI, news and updates, Medicare EDI format descriptions, EDI formats for downloading and detailed instructions for completing both the UB-92 and HCFA-1500 (12/90) forms.

Access to the HCFA Internet Homepage is available in two ways:

1. Enter the URL address:
   
   http://www.hcfa.gov/medicare/edi/edi.htm

2. Enter the URL address:
   
   http://www.hcfa.gov

   This method takes you to the HCFA Internet Homepage. When you have accessed the homepage:

   ♦ Click on Medicare.
   ♦ Click on Professional/Technical Information.
   ♦ Click on Electronic Data Interchange.

In addition to the new Internet access, Medicare EDI information can be accessed from the BPO Bulletin Board by dialing [410] 786-0215.
ELECTRONIC DATA INTERCHANGE (EDI)

Offset/overpayment through CSI

NEW SCREENS! NEW SERVICES!

Palmetto GBA’s Electronic Data Interchange Claim Status Inquiry offers offset/overpayment functionality for DMERC Region C electronic submitters. Through this feature, submitters can research in detail offsets and/or overpayments displayed on a remittance notice. Offsets and overpayments can be viewed by using either the 10-digit supplier number assigned by the National Supplier Clearinghouse or the financial control number located on the remittance notice.

Overpayment information includes claim control number, date of service and amount of overpayment. Offset information lists all money offset for each remittance, as well as current total offset information.

CSI users may access offset/overpayment features by typing “OPIQ” at the blank screen instead of “PAME” or “VPIL.” Instructions for using offset/overpayment features may be downloaded from the EDI Bulletin Board System. (See below.)

For more information or to enroll for CSI, call the EDI Help Desk at (803) 788-9751.

Bulletin Board System

The EDI Bulletin Board System contains a library of Medicare information such as DMERC advisories, supplier manuals, procedure codes, diagnosis codes and fee schedules. Users can also download reference materials such as EDI order forms and EDI software manuals. There are no enrollment forms to complete; simply follow the LOG ON procedures below.

NOTE: These instructions cannot be used to transmit claims or retrieve reports via the BBS. If you would like to transmit claims or retrieve edit reports via the BBS, contact the EDI Help Desk at 803-788-9751 to request a Bulletin Board Enrollment Form.

To use Palmetto GBA’s BBS, all you need is a PC and:

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