Region B Council A-Team Questions
June 2006

Disclaimer: The Region B Council A Team Participants have provided the following questions. The answers and references cited are correct as of the publication date. TriCenturion has provided input on questions pertaining to Medical Policy and Benefit Integrity, denoted with an *.

Please note: As of March 1, 2006, TriCenturion was granted Program Safeguard Contractor (PSC) responsibility for Region B DMERC. PSC responsibilities include Medical Policy, Medical Review, and Benefit Integrity. Please refer to our Website www.adminastar.com, TriCenturion's Website www.tricenturion.com or visit the Centers for Medicare & Medicaid Services (CMS) Website www.cms.hhs.gov for recent updates.

Home Medical Equipment

1. How do the changes in capped rental for DME (no longer patient choice to continue renting) affect the equipment (new or used) provided initially to the patient? Is new equipment required to be provided?

   The Deficit Reduction Act of 2005, §5101(a) revises the payment rules for capped rental DME only. The Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) §30.5 - Capped Rental Items provides instructions as to how capped rental items shall be billed and paid. Currently there are no provisions requiring the supplier to provide new versus used capped rental equipment to Medicare beneficiaries.

2. If the HCPCS code is a replacement part by definition, i.e. "E0967 Manual Wheelchair Accessory, hand rim with projections, any type, replacement only, each" is the RP modifier required when billing?

   When a HCPCS code is a replacement part by definition, the RP modifier is not required. In the example provided above (E0967), this code can not be billed with a new wheelchair base. Based upon the definition of the code it is expected that this code is included with the base of the wheelchair.

Enteral/Parentral/IV Therapy

No questions submitted.

Respiratory Care Equipment/Oxygen Therapy

3. Under the DRA provision to shift ownership of oxygen equipment to patients, will Medicare compensate suppliers for an emergency response system currently in place (on call staff) even if no repair is necessary? If not, does Medicare intend for patients on their patient owned life sustaining equipment to call 911 after the equipment ownership is transferred to the patient, if there is an problem with the equipment?

   ***TriCenturion does not have any comments, as this is not deemed an issue for the contractor to address.**

4. If we have a customer who is a snow bird traveling to another state for the winter and is using our oxygen, can we continue to bill the monthly rental if the patient takes a home fill unit i.e., a portable concentrator that enables the patient to fill his/her own portable oxygen tanks? We will be supplying the customer with names of suppliers in the area where they are going to make sure they are taken care of in case of any emergency.

Yes, in this situation the patient takes the portable concentrator and tank to their temporary location, the supplier is entitled to continue billing the monthly rental to Medicare. It is imperative that the supplier stay in contact with the patient to ensure that the claims are submitted to the appropriate contractor for payment, should the patient change their address.

5. In regard to CPAP (E0601) coverage, this question is in 2 parts.

   Client A - Had initial sleep study September 1997, total events were 85, time in bed 206.0 minutes, total sleep time 107.5 minutes.

   This client met the Medicare guidelines at the time of initial setup and other policy changes over the years. He now comes in for replacement parts (mask, headgear, tubing, filters, etc), and DOES NOT MEET CURRENT REQUIREMENTS due to Medicare's change of policy, specifically the sleep time now needing to be a minimum of 120 minutes.
   Does he need to have a repeat qualifying sleep study in order for us to bill with the KX modifier so the supplies are paid for? Can we bill without the KX modifier, get the denial, send claim to Redeterminations with documentation from chart that he has been using and continues to use CPAP and getting replacement supplies?

   A qualifying sleep study is not required to bill for replacement parts since the beneficiary met the Medicare guidelines at the time of initial set up. The Local Coverage Determination (LCD) for Continuous Positive Airway Pressure System (CPAP) (L11528) specifically states:

   CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY:

   "Continued coverage of an E0601 device beyond the first three months of therapy requires that, no sooner than the 61st day after initiating therapy, the supplier ascertain from either the beneficiary or the treating physician that the beneficiary is continuing to use the CPAP device".

   Therefore, if the patient met Medicare Coverage Criteria at the time of initial set up, suppliers are required to secure a statement from the treating physician or beneficiary, documenting that the beneficiary is continuing to use the CPAP device. This documentation would support the use of the KX modifier for the replacement supplies.

   Client B has been using CPAP in the past, did not meet 2005 requirements, had new sleep study, BUT was unable to sleep during sleep study (unable to use CPAP unit during sleep study), does have enough apneas/hypopneas; but did not sleep for 120 or more minutes during the course of a full night study. Can we bill without the KX modifier, get the denial, send claim to review with documentation from chart that he has been using and continues to use CPAP and getting replacement supplies?

   Based upon the scenario provided above, although the patient was entitled to Medicare benefits, the patient did not meet the coverage criteria outlined in the LCD. The claim for this service must be submitted to Medicare without the KX modifier, because the coverage criteria for this specific patient has not been met. As with any claim that is denied due to medical necessity, appeal rights are afforded, however, all carriers are mandated to follow the National and Local Coverage Determination. (Please refer to the Region B DMERC March 2003 Supplier Bulletin *CPAP and Respiratory Assist Devices – Apnea/Hypopnea Index* pages 4-5)

   This article may be viewed on our Website at:
   http://www.adminastar.com/Providers/DMERC/Bulletins/2003/files/March2003DMERCBulletinFinal.pdf

How many times per lifetime will Medicare pay for a new sleep study to re-qualify patients for reimbursement for CPAP equipment/supplies? Or does the initial qualifying sleep study cover the person for the lifetime need?

There is no requirement that a sleep study be performed within any specified time prior to initiation of therapy. With regards to the number of times per lifetime Medicare will pay for a new sleep study, the Region B DMERC does not have jurisdiction over this service. Please contact the local carrier for coverage criteria and payment guidelines.

6. Client C received set pressure CPAP unit 2-11-03, rental unit for 2 months and returned unit 4-7-03. Dr. then re-ordered unit and was setup on 5-3-04, rented unit for additional 8 months and returned unit again on 12-09-04. Dr. now wants to have patient try an auto-titrating unit (E0601), What is the time frame of a client that has returned a unit before a New Rental Period can start over? (It's been about 1 ½ years). If unable to start new rental period, with an ABN signed prior to client receiving the different unit, can we bill the patient for the additional months of rental if Medicare will only pay for 3 more months?

   In order for a new capped rental period to begin, the interruption in the use of the previous equipment must be at least 60 days plus the days remaining on the initial Certificate of Medical Necessity (CMN). In the scenario provide above, the patient must have been without the use of the CPAP from 12/09/04 through 02/09/05 plus the days remaining on the initial Certificate of Medical Necessity (through 05/03/05).

   For additional information please refer to the break in service flow chart and the break in service electronic submission instructions at:
   http://www.adminastar.com/Providers/DMERC/MedicareManuals/files/BreakInServiceBillingChart.pdf and
   http://www.adminastar.com/News/EDINews/files/ElectronicBreakInServicearticle_webposting.pdf

7. We have a patient that had a sleep study done on 3/24/06 for a CPAP that would have qualified based on Total Recording Time (133 mins) and met all other requirements. However, he had a Total Sleep Time (TST) of 59 minutes. The sleep labs were not aware that on 3/9/06 a list-serve message was sent out stating that the March Bulletin had come out stating that effective 1/1/06 the definition of AHI was changed to reflect NCD, TST had to be 120 minutes or greater. Would this person have to be re-tested to qualify under Medicare's Coverage Criteria that was retro active or would they qualify because at the time of the study to the best of their knowledge the patient did qualify? Although the Bulletin was put on the web site on 3/9/06 it is not feasible that everything contained in the bulletin could be distributed and enforced on that same day. In this example if we were given a grace period to implement the change in policy we would not have to have beneficiaries go back and repeat a very costly sleep study. Would we be compliant if we billed the CPAP and supplies with the KX modifier in this example?

   ***All patients must meet the coverage criteria outlined in the National Coverage Determination (NCD). In the scenario provided above, if the sleep study conducted did not meet the coverage criteria outlined in the NCD or the LCD during the time that the services were rendered, the patient would need to be retested to qualify. Grace periods were not implemented due to omission of the 2 hour requirement. The NCD has always listed this as a requirement.**

8. We have received several denials for Heated humidifiers for CPAPs where the patient was originally set up with cool air humidification over a year ago and now require heated humidity in their therapy. The denial is same or similar equipment and we would like to know why we are receiving this denial?

   The Medicare guidelines will allow for either a non-heated (E0561) or heated (E0562) humidifier when ordered by the treating physician for use with a covered E0601 device. Based on the scenario provided above, your initial claim for the E0562 must be submitted to break in service due to the change in equipment. Although the

policy states one or the other, a physician's order is required for both and the supplier is not allowed to alternate billing.

For additional information please refer to the break in service flow chart and the break in service electronic claim submission instructions at:
http://www.adminastar.com/Providers/DMERC/MedicareManuals/files/BreakInServiceBillingChart.pdf and
http://www.adminastar.com/News/EDINews/files/ElectronicBreakInServicearticle_webposting.pdf

9. How will Medicare handle an oxygen conserver system after the 36 month cap has been met? Will the provider just be out the cost of the unit. Will Medicare provide additional coding to the providers to allow for billing of refills? If reimbursement on refills is allowed, how would a provider measure/record these fills?

   AdminaStar Federal does not have any comments for this inquiry as CMS has not provided instructions for this specific issue.

10. It's common for a provider to place a "loaner" unit in the patient's home, while the concentrator, etc is being repaired. The policy does not address rent of a unit while a patient owned unit is being repaired. We may service a patient that had capped under a different provider. If Medicare will rent a unit in this scenario, does a supplier have to obtain a 484 O2 CMN?

    There is no additional payment for oxygen equipment "loaners". All of the costs associated with the provision of oxygen are calculated into the monthly rental payment.

11. Although oxygen refills are addressed in the policy, oxygen supplies are not. Will these be reimbursed?

    OXYGEN ACCESSORIES:

    Accessories, including but not limited to, transtracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent (E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353), and stand/rack (E1355) are included in the allowance for rented systems. The supplier must provide any accessory ordered by the physician. Accessories are separately payable only when they are used with a patient-owned system that was purchased prior to June 1, 1989. Accessories used with a patient-owned system that was purchased on or after June 1, 1989 will be denied as noncovered.

12. When the patient qualifies on exercise, the oxygen policy clearly states: "When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three (3) oxygen studies in the patient's medical record – i.e., testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia). Only the qualifying test value (i.e., testing during exercise without oxygen) is reported on the CMN.

    The other results do not have to be routinely submitted but must be available to the DMERC on request." Is there a time limit for the three tests to be done…another words, are they all to be done at the same time? Or can they be done at different times as not all physicians have O2 at the office to complete the qualification process. Please clarify.

    ***All tests must be conducted within the protocol established by the lab. Remember that exercise oximetry testing is a formal lab test not, as believed by many, an informal collection of values done in an uncontrolled fashion. Based upon the nature of this question, it appears that reference is being made to the latter, in which case, the results would not be valid during an audit.**

13 Are supplies for RAD (E0471 & E0472) which moved from the Frequent & Substantial Service category to the Capped rental policy in April, now separately billable? MM4223 does not address this.

Yes, RAD accessories are separately payable. Please refer to the LCD for Respiratory Assist Devices for billing parameters.

Prosthetics/Orthotics

14 Is there a list of L codes that are not billable by a DMEPOS supplier, if their specialty code is not 51 thru 52?

An all inclusive list is not available for L codes requiring the supplier to be licensed. Under the provisions of Change Request 3959, Medicare payment may only be made for prosthetics and certain custom-fabricated orthotics when furnished by physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel and prosthetics personnel. Therefore, all prosthetics and any custom fabricated or custom fitted orthotics are restricted by this requirement.

Rehab Equipment

15. For power wheelchair repairs, does the policy stated below apply? Often we are replacing an accessory during a repair and it is not possible to get a written order prior to the delivery of the power wheelchair. Please clarify.

Medicare Policy:
For an option or accessory for a manual wheelchair to be covered, a written signed and dated order must be received by the supplier before a claim is submitted to the DMERC. If the supplier bills for an item without first receiving the completed order, the item will be denied as not medically necessary. (See related Policy Article for information on order for power wheelchair accessories.)

If a power wheelchair accessory is delivered before a signed and dated order has been received by the supplier it must be submitted with an EY modifier added to each affected HCPCS code. For an option or accessory for a power wheelchair to be covered by Medicare, a written signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to the receipt of a written order, it will be denied as non-covered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

Revision History Explanation

Revision Effective Date: 01/01/2006
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added requirement for a written order prior to delivery for power wheelchair accessories.

***It is not required that the supplier obtain an order from the physician for the repair of patient owned equipment. Repair claims submitted for patient owned equipment should indicate in the note segment (for EMC claims) or in box 19 (for paper claims) "Patient Owned Equipment**".

16 How can we bill a POV or a Power Wheelchair for denial when the patient does not qualify but another insurance will pay?

This situation is currently being addressed by The Region B DMERC. An educational article will be issued once a resolution has been determined.

17 Will there be a special purchase option form for power chairs or are we to continue with the one we already have?

Chapter 14 of the Region B DMERC Supplier Manual offers a sample rent/purchase option letter that will be revised at the time that the CMS Internet Only Manual (IOM) is revised. Change Request 5010 states changes to the Medicare Claims Processing Manual publication 100-04 and the Benefit Policy Manual publication 100-02 will follow at a later date to facilitate the changes made to the payment of Capped Rental DME and Oxygen and Oxygen Equipment.

Documentation/Regulatory/Miscellaneous

18. How will we handle transition patients from another supplier? Example – Patient lived in Nevada and has rented a wheelchair for 11 months. Patient moves to WI in the 12th month and requests a wheelchair from a different supplier. Does the new supplier have to dispense?

Capped rental payments made on equipment with an initial date on or after January 1, 2006 will be paid until the 13th month. The Supplier owns the piece of equipment until the 13th month and can decide to pick up the equipment if a beneficiary moves. The beneficiary should try and work with the existing supplier in this instance. If the existing supplier opts to pick up the equipment, the beneficiary would not begin a new capped rental period for the same equipment if received by a new supplier. This would be a business decision that the new Supplier would have to make.

19. MM5010 states "DME MACs will limit the total number of months for which they make payment for capped rental DME to 13 months. They do not address Break in service in this policy. From the wording, it appears that break in service will no longer constitute a new capped rental period. Is that correct?

***Break in Service and/or Break in Billing situations alone do not constitute a new Capped Rental Period. Please reference the AdminaStar Federal Web site (www.adminastar.com) and click on the DMERC Manuals and Forms page for the Break in Service/Break in Billing flow chart. Please follow the electronic claim submission instructions for Break in Service procedures as outlined in the article titled "Electronic Submission for Break in Service Claims".**

20. The March 2006 questions about not dating the physician's signature, (Q #33) seems to say that physician cannot use stamped signatures and/or dates on detailed written orders. The manual states "Before submitting a claim for any DMEPOS item to the DMERC, the supplier must have a detailed written order (original "pen and ink", signature stamp, facsimile image, photocopy, or electronic) which has been both signed and dated by the treating physician." Why would the physician use a signature stamp AND sign and date the order. This seems redundant. Please clarify.

***The requirement is for the physician to sign and date the order. There is no prohibition against typed dates. The date, handwritten, typed faxed, computer- generated, etc… must be the date the document was signed.**

21. How will Region B access the recertification CMNs on file for Region C patients that begin billing Region B with the July 1, 2006 dates of service and after?

Change Request 5082 outlines the data that will be made available to DME MAC Jurisdiction B on July 3, 2006. Online claims, claims in history and CMN files will be available to the DME MAC for Kentucky beneficiaries.

22. a) How can we clearly indicate on a claim for an item that the person does not meet coverage criteria and the claim needs to be denied? We may need a denial for another insurance, or the customer may want to rent non-assigned for non-covered use (i.e. outside the home only, pump for convenience, etc). Claims now are being paid that should not be. Is there a modifier that we can use?

    b) If we file a claim in such a case, and we are paid but should not have been, what is the best method for notifying the DMERC of the overpayment, making the refund, and re-processing the claim for an appropriate denial? We need to be able to do this in a timely manner. The biggest difficulty seems to be getting the claim corrected and getting a claim remittance/denial code. How long will this process take? Please document a clear procedure.

    c) If the supplier sends the mis-paid claim through the 1st level reconsideration process with clear statements on the reconsideration that the item is NOT covered but the DMERC does not act on the information, can the supplier close the case and accept the payment; even if the supplier has documentation which would indicate non-coverage in its files? How far must the supplier push the claim in order to have the DME MAC request a refund?

    Please refer to question/answer 16.

23. What is the status/time frame for eliminating the 'dummy' CMN submission for WCs?

    Change Request 3952 indicated that April 3, 2006 would be the implementation date for the CMS systems changes to allow wheelchair claims to be submitted without a CMN. The article titled Wheelchair CMNs-Transition Instructions explains that the CMN Transition instructions were only to be used until April 2006 . The Region B DMERC currently accepts claims submitted for wheelchairs without a CMN. To review this article please copy the following into your internet browser:

    http://www.adminastar.com/Providers/DMERC/MedicalReview/files/WheelchairCMNsTransitionInstructions.pdf

24. What kind of documentation will be required when hospital bed CMNs are eliminated in October?

    ***Policy revisions incorporating the CMN changes are currently in progress that will address how these claims need to be documented for routine claim submission. For audit purposes, the standard has not changed. It is expected that the medical record should contain sufficient information for a determination about whether the patient meets the relevant policy criteria can be made.**

25. We are receiving a denial OA109 on an item delivered to a patient in an Inpatient setting within the 48 hour time frame prior to discharge. My question is, should we bill based on the delivery date or the date of discharge? Our delivery records will indicate one date and our billing another. What documentation should be attached to a reconsideration request?

    Page 26 of the December 2001 Region B DMERC Supplier Bulletin explains that the date of discharge is deemed to be the date of delivery of the item. The discharge date must be the date of service for the purposes of claim submission. No one may bill for days prior to the date of discharge. An OA 109 denial is resubmittable.

26. The CMS website: (http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp#TopOfPage) says that starting October 2, 2007 "Medicare will be capable of sending the National Provider Identifier (NPI) as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions." What does capable mean? Does

the provider indicate when they're ready to receive the NPI on electronic remittance advices (ERA), etc? Or is it based on whether the NPI came in on the claim? Or would you have the NPI from the NPPES system even if the provider did not enter the NPI on the claim?

Please refer to The Centers for Medicare and Medicaid Services (CMS) Change Request 4320 dated February 1, 2006.

The provider does not indicate when they are ready to receive the NPI on ERAs, CSI and eligibility requests.

In Stage 2 (October 2, 2006 - May 2, 2007), Medicare will return the NPI on the outbound secondary claim (for a crossover), claims status response (276), remittance advice (835) and eligibility response (277). NPIs, when available in the Medicare provider files, as well as legacy identifiers will be returned on the electronic remittance advice (835) and SPRs.

In Stage 1 (January 1, 2006 - October 1, 2006) and Stage 2, Medicare will allow NPIs on the eligibility inquiry (270) and the claim status inquiry (276). The NPIs will be returned in the eligibility response (271) or the claim status response (277), as long as the legacy identifier is also reported in the transactions.

Medicare will receive a crosswalk file from the NPPES system. The NPI entered on the claim will be verified against the crosswalk file. If the NPI is on file in the Medicare provider file, the NPI will be returned on all the HIPAA transactions listed above.

27. Is there a way for suppliers to receive test 835s that contain the NPI prior to October 2, 2007?

No. The standard Medicare systems do not have the programming completed or in place to populate an NPI on the Electronic Remittance Advice (835). AdminaStar Federal will begin release testing in September for the October release implementation.

Please refer to The Centers for Medicare and Medicaid Services (CMS) Change Request 4320 dated February 1, 2006. Stage 1 (January 1, 2006 – October 1, 2006) states that the NPIs will NOT be reported on the X 12 835 claims or Standard Paper Remittance (SPR) format, even if an NPI was submitted on related claims.

It also states that for Stage 2 (October 2, 2006 – May 22, 2007), an NPI, when available in the Medicare provider files, as well as legacy identifiers will be returned in 835 transactions and SPRs.

28. We recently had an outside agency provide education for us regarding Medicare Secondary Payer. We were told by this agency that for ongoing rentals and people who purchase the same supplies routinely, we need to ask the Admission Questions provided in Chapter 4 of the Medicare Manual, every 90 days. If the person qualified for Medicare for the equipment or supply at initial set-up or start, is it necessary to ask these questions every 90 days? Also, must these questions be asked in person or can it be some type of written communication as long as we ask the questions in the suggested form provided in Chapter 4?

Medicare Secondary Payer (MSP) Manual Publication 100- 05, Chapter 3, section 20.1 stipulates that providers are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare. This must be accomplished by asking the beneficiary about other insurance coverage. Section 20.2.1 lists the type of questions providers must ask of Medicare beneficiaries for every admission, outpatient encounter, or start of care. The policy for recurring outpatient services gives hospitals not DMEPOS Suppliers a requirement of 90 calendar days from the date of service for verifying MSP information.

29. Is there a plan to tell providers which Medicare HMO a beneficiary has chosen via the Interactive Voice Response (IVR) unit?

    The supplier's intake process should begin by obtaining the beneficiary insurance information. Beneficiary eligibility can be accessed through the IVR at 1-877-299-7900 or through Claim Status Inquiry (CSI). Currently there are no plans to add Medicare HMO information, but a customer service representative (CSR) can provide this information. Once eligibility information is obtained through the IVR, the supplier has the option to opt out to speak with a CSR to obtain the name and status of the Medicare HMO plan.

30. Is there a way a supplier can obtain a fax copy of beneficiary eligibility from the IVR?

    No, not at this time. It is recommended that suppliers should obtain a copy of the beneficiaries Medicare card for their records. Claim Status Inquiry (CSI) provides Beneficiary Eligibility Inquiry capability. The Beneficiary Eligibility option allows CSI-enrolled suppliers and their authorized billing agents to access beneficiary eligibility data. This is confidential information and is subject to penalties and fines up to $5,000 under the Privacy Act for illegal disclosure. Beneficiaries eligible for DMERC coverage must be entitled to Medicare Part B benefits. The data is subject to change and should be considered valid only at the time of inquiry. Information for Medicare Part B, Health Maintenance Organizations (HMOs) and Medicare Secondary Payer (MSP) is current, but suppliers should always develop for the most up-to-date information.

    Note: The fact that eligibility information is not found for a particular beneficiary does not necessarily mean that the person is ineligible for Medicare. Likewise, you may find data for a beneficiary who currently is not eligible for Medicare. The ultimate determination of a beneficiary's Medicare eligibility can only be determined when submitting a claim for that person.

31. Would it be possible for a list of approved cross over payers to be provided to the supplier community by the DMERC?

    Yes, CMS plans to publish a complete list of trading partner names and their coordinating Coordination of Benefits Agreement (COBA) identification number(s) on the CMS Web site. Initially, the list will contain all insurer names and COBA IDs for all commercial insurers and those Medicaid agencies in COBA production.

    There are plans to publish this list soon. The list will be updated regularly as additional trading partners participate in the COBA consolidated claims crossover process. In addition, the list will be updated to include the customer service numbers of those trading partners in COBA production.

32. We would like clarification on the letters we have been getting that say our claims that were marked for crossover, did not crossover. I get these every week. They say they did not cross over due to "claim data errors". I have an example if you need it. What causes the crossover to error this way and when will the situation be corrected? Is this a supplier submission problem or a DMERC processing problem?

    After reviewing several claim examples, the claims included more than one Date (DTP) segment in the Service Line loop (2400). An electronic claim can be submitted to AdminaStar Federal with multiple Date (DTP) segments in any order. Medicare does not front end edit the order of the segment on an electronic claim.

    The system of GHI, the Coordination of Benefits (COB) contractor does edit the order of the segments. It requires that the Service Date (DTP) be transmitted first. Since the service date was transmitted as the second,

third, etc. DTP in the Service Line loop, the electronic claim was not crossed to the secondary insurance carrier by GHI.

AdminaStar Federal forwarded an inquiry regarding this issue to GHI and CMS is also aware of this issue.

At this time we suggest that you contact your software vendor and ask that they change the order of the Date (DTP) segments and transmit the Service Date (DTP) first in the Service Line loop (2400). AdminaStar Federal will notify suppliers via our Web site and listserv when this issue is resolved.