Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1297

SUBJECT: Claims Processing Instructions for the DMEPOS Competitive Bidding Demonstration

This Program Memorandum (PM) contains the standard systems changes required for the DMERCs to process demonstration claims received on or after January 1, 2001, in the San Antonio, Texas site for the DMEPOS Competitive Bidding Demonstration.

Background

This demonstration is required by the Balanced Budget Act of 1997, and included in the President's Plan to Strengthen and Modernize Medicare. It implements a test of competitive bidding as a way for the Medicare Program to pay for medical equipment and supplies. Several studies have shown that the Medicare Program and its beneficiaries often pay more for medical equipment and supplies that other insurers and even individual patients. This demonstration requires suppliers to submit bids, including quality and price information, to provide access for Medicare beneficiaries at a more reasonable cost to beneficiaries in the Medicare Program. Also, because the bidders will be evaluated for ethical behavior, bidders with unacceptable records of program compliance will be rejected, thus helping to reduce Medicare fraud and waste.

The first site for the bidding demonstration was Polk County Florida, where bids were solicited for five product categories: oxygen, hospital beds, enteral nutrition, surgical dressings, and urological supplies. The project received 73 bids for the items, chose winning suppliers, and saved an average of 17 percent compared with the regular Florida fee schedule. The demonstration was implemented on October 1, 1999, and has gone very smoothly, with beneficiaries having continued access to products that they need, and additional quality standards have been implemented to assure high quality products and services.

The second demonstration is now in preparation in San Antonio, Texas. Beneficiaries in Bexar, Guadalupe, and Comal Counties are affected. Bids were received from suppliers on June 23, 2000 for five product categories: oxygen, hospital beds, nebulizer inhalation drugs, manual wheelchairs, and non-custom orthotics. In the summer and fall of 2000, the DMERC, Palmetto GBA, will evaluate the bids, propose a list of winning demonstration suppliers to us, and send out directories of the suppliers to Medicare beneficiaries. Based on the bids received, we anticipate a successful bidding demonstration at this site. The demonstration will be implemented at the San Antonio site on January 1, 2001, and will operate for 2 years. After the conclusion of the demonstration, payment methods will revert to the normal Medicare fee-for-service DMEPOS payment methods.

REQUIRED SYSTEM MODIFICATIONS

The specific bid model selected by HCFA dictated the systems changes required for implementation of the competitive bidding demonstration. The model designated uses a reimbursement methodology that allows reimbursement only to Demonstration Suppliers based on the composite bid prices of the winning suppliers. Non-demonstration Suppliers are denied reimbursement except under the conditions of grandfathering as defined in this document. The primary changes that were made for the VIPS system for this demonstration were designed to support the project regardless of the product category bid and the metropolitan areas (MAs) selected for the demonstration. Once the changes are made to accommodate the first demonstration, which was implemented on October 1, 1999, in Polk County Florida, minor modifications will be required to accommodate the future demonstrations including changes required to add new product categories and new locations.

I. SITE ONE

The VMS system modifications are divided into three parts: Master File Impacts, Claim Processing Logic Impacts and Reporting Requirements. These changes were implemented in a two-release approach to allow the project to be installed in phases, which allowed for maximized testing window and minimum risk. VIPS created the ability for the pricing logic to be controlled by a new SPOT flag that the carrier could turn on in production when ready. The software for this project had to be elevated on a release boundary; therefore phase one was implemented with the April 1999 release but was not activated until the SPOT switch was set in October 1999. The second phase, which included primarily the Reporting Requirements, was implemented in the July 1999 release. The modifications required for the first demonstration to the Master Files, the Claims Processing Logic, and to the Reporting System are described below.

Master File Impacts

The Master Files that required modification to support the demonstration are:

ACEMASTR – This file identifies whether the HCPCS Procedure Code submitted on a claim is part of the demonstration. Five new Procedure Option values were added to the system to identify these codes.

VMAP PARFFILE – A new parameter table was added to the VMAP to link the demonstration 5-digit zip codes to two-position MA codes. This required the addition of a new data entry screen, and a conversion procedure and program to load an initialized filed. Changes were required to the SAFE audit file to capture before and after screen images whenever the VMAP ZIP code table record is added or updated. A new SPOT option was added to VMAP to give the users control over the actual activation of this project's logic.

PROVIDER File – A new record type was added to the Provider file, called the BID record. A supplier will have one BID record for each bid site it is associated with. A new screen will be added to the APPL subsystem to allow adds, updates, deletes, and inquiries to the BID record. Absence of a BID record will indicate that a supplier is exempt. This requires a BID record to be established for all Demonstration and Non-Demonstration Suppliers.

A new flag called the physician/supplier flag was added to the provider file. This flag was manually set by DMERC personnel to identify all suppliers that are considered physician/supplier.

VIPS created a new program to perform the initial load of BID records. The file provided to VIPS by the DMERC was in a mainframe format. A report was generated to display the date that was loaded to the Provider file as well as to flag Demonstration Suppliers that have not been approved as EMC submitters.

The mainframe file that the DMERC provided to VIPS to use to load the BID records to the provider file where each Bid Switch in the format indicates the supplier's status for a bid category – Demonstration (P), Non-Demonstration (N) or Non-Bidder (X).

As the second round of bidding occurs, the current BID record data will need to be 'rolled' in the file to allow for new BID data. A batch process will be created to accomplish this task.

AREA/PREVAILING Pricing File – This file did not require any changes to format or layout, however it was systematically loaded with the prices for the first site. VIPS created a new program to perform the initial load of pricing data. The PIDS reporting was modified to display the bid prices for Demonstration Suppliers in addition to any customary prices for non-bid products. Bid versus non-bid prices are denoted by a new footnote that was added to the PIDS reporting. Modifications were also made to the PIDS reporting to allow for only the inclusion of the metropolitan area on the report in addition to the existing selection criteria of carrier-wide and fee-schedule inclusion.

As the second round of bidding occurs, the current pricing data will need to be 'rolled' in the file to allow for new BID prices. Changes will be required to the existing PDS programs to ensure that when the yearly PDS process runs, it rolls everything but the new demonstration site pricing.

Claims-In-Process (CIP) File – The CIP file was modified to store the MA code, the beneficiary 5-digit zip code, and a switch to indicate how the line was priced in order to facilitate reporting requirements. Along with the change to the CIP copybook, the programs that initialize the CIP record for new claims were modified for these fields.

BENEHIST File – The Beneficiary Claims History File stores the new fields defined for the CIP file. The programs that create history records from adjudicated claims were modified to move the new data.

BENEID File - The Beneficiary Identification File allows an ALGS letter to be sent to a beneficiary when a first and second claim is submitted by a Non-Demonstration Supplier for a bid product if the beneficiary is located in a demonstration MA. The ALGS letter will notify the beneficiary that their supplier is not a Demonstration Supplier and outline the consequences of continuing to patronize these suppliers. The BENEID file was modified to hold a new 'First Demo Claim' switch. The first and second demonstration claim for a beneficiary, which is submitted by a Non-Demonstration Supplier, will be 'paid' from an on-line perspective. The flag on the BENEID file will be set. The 'First Demonstration Claim' flag on the BENEID file is not changed once it has been set by the on-line processing system. BUDS01 was modified to display this switch. The BUDS reporting was also modified to display the new First Demo Claim switch.

New BUDS Screen – A new BUDS screen was developed and added to the VMS system to identify demonstration claims details for customer service representatives.

Claims Processing Logic Impacts

A substantial portion of the modifications that were made to VMS for this project was coded in the claims pricing modules. Factors used in considering how to price a line are:

- HCPCS with one of the new MPR Processing Options
- Beneficiary ZIP Code in MA
- Supplier BID record on file
- CMN (for enteral nutrients, supplies, and poles)
- Place of Service
- Claim billing indicator

If a line is subject to the new pricing strategy, the system then determines how the line should be priced using the BID switches from the Provider file, the Place of Service code on the claim line, the billing indicator, and the kind of service being rendered (i.e., capped rental vs. oxygen vs. enteral).

The pricing logic contains the most complicated code in the VMS on-line system. DMERC-specific modules calculate prices based on DMEPOS category since each class of equipment in the first site has different pricing guidelines. The system had to ensure that the claim is priced at the lower of the IIC, bid allowance, or the submitted amount. All DMERC-specific modules had to be modified to perform bid pricing along with the current pricing logic with extra attention given to ensure that existing processing was not impacted by the bid changes. These code changes had to be transparent to the other DMERCs. Pricing traces, available in the on-line and in QA, had to be modified to capture these new logic changes.

The transition between rounds and between pre-demonstration period and the first round posed the greatest level of complexity to this process. "Grandfathering" or transition policies (which keeps existing reimbursement rules in place after a bidding round begins) were required for all capped rental, enteral pumps, and oxygen services rendered by Non-Demonstration Suppliers. These policies do not apply to "First Demonstration Claim" processing.

Additional changes requested to the claims processing logic include the following:

- Claims submitted by Demonstration Suppliers for bid products must be submitted via EMC. If a Demonstration Supplier submits a paper claim, the claim is returned/rejected. If a Demonstration Supplier submits a paper claim with both bid and nonbid products, the claim is plugged with a split indicator. The batch adjudication then creates two claims, one with the nonbid products is returned/rejected and the other services are processed through the system. This required a new return/reject remark code and a new return/reject action code.

- Claims submitted by Demonstration Suppliers for bid products must be assigned. If a Demonstration Supplier submits a nonassigned claim for bid products, the assignment indicator is automatically flipped to "A" by the on-line batch system. If a Demonstration Supplier submits a nonassigned claim with both bid and nonbid products, the claim is plugged with a split indicator. The batch adjudication then creates two claims, one with the nonbid products remaining nonassigned and the other services are processed through the system as assigned.

- Processing of claims for beneficiaries having a representative payee posed an additional requirement to ensure that the system stores the MA associated with the beneficiary ZIP code and not the representative payee's ZIP code. EMC logic was changed to move the beneficiary's 5-digit ZIP code to the claim record. The on-line claims entry screen was modified to allow the entry of the beneficiary's 5-digit ZIP code. Also, an additional edit was installed to require that the beneficiary's 5-digit ZIP code be entered if a representative payee situation is detected.

Reporting Requirements

A new reporting subsystem was developed for this project to allow the demonstration staff and the DMERC to closely monitor the demonstration's effectiveness. These reports are provided on a monthly basis unless otherwise noted.

- Nonassigned Claims submitted by Demonstration Suppliers
- Claim Summary by Provider Bid Status (weekly)
- Beneficiaries using Non-Demonstration Suppliers (weekly)
- Beneficiary-filed Claims Subject to the Demonstration (weekly)
- Physician-filed Claims Subject to the Demonstration
- High Dollar Claims by Category
- Bid Beneficiaries with Other Insurance
- Comparison Reports by MA

Report detail includes the number of claims paid, total allowed amounts, the number of services allowed, the number of claims denied, and the number of beneficiaries impacted. If any lien contains a code from one of the bid product categories and has allowed charges greater than zero, the claim is counted as "paid"; otherwise, the claim is counted as denied.

Technical Impacts

There are no changes in this demonstration that should significantly impact on-line or batch runtime. However, changes do impact most major subsystems, including APPL, BUDS, VMON, VMAP and Adjudication.

II. SITE TWO

The bid model for the second demonstration site will mirror the bid model as the first demonstration. It will also use a reimbursement methodology that allows reimbursement only to Demonstration Suppliers based on the composite bid prices of the winning suppliers. Non-demonstration Suppliers are denied reimbursement except under the conditions of grandfathering as defined in this document.

The primary differences involve changes in the product category and the MA. The product categories to be bid in site two are:

Oxygen Services
Hospital Beds and Accessories
Nebulizer Drugs
Non-Customized Orthotics
Non-Customized Manual Wheelchairs

Slight adjustments will be required in the ACEMASTR (which is a Master File impact) to add three new Procedure Option values to identify the new HCPCS procedure codes in the product categories for site two as claims are processed.

The VMAP Parameter table has to be updated to expanded to link the site two 5-digit ZIP codes to the new two-position MA codes for site two. Therefore, the new ZIP codes for the three demonstration counties in San Antonio will have to be loaded. The current VMAP locality table, which is used to determine participation in the competitive bidding demonstration based upon the ZIP codes in the MA and surrounding areas, is sufficient to handle the identification of beneficiaries with the new MA and the surrounding area suppliers.

VIPS will use the program created for the first site to perform the initial load of BID records for site two. Once again, Palmetto GBA will provide a file to VIPS for this load in a mainframe format.

The AREA/PREVAILING Pricing file will not require any changes to format or layout for site two. However, it will be systematically loaded with the demonstration prices for the San Antonio metropolitan area.

The claims processing logic impacts are essentially the same for the second demonstration. However, due to differences in the transition policy for the orthotics product category than the site one product categories, specific coding must be developed by VIPS to allow no "First Demo Claim" payments and ALGS letters.

There will be no additional categories of suppliers beyond the current Demonstration Suppliers, Non-Demonstration Suppliers and Exempt Suppliers. There will be no changes in the rules governing the processing of these supplier categories within the demonstration.

Finally, there will be no additional reporting requirements, or training or additional documentation requirements, beyond necessary updates to the VMS competitive bidding

demonstration manual. The same reports currently generated for site one will also be generated for site two.

MSN Messages

The following are the Medicare Summary Notice (MSN) messages that will be used for the demonstration in both English (E) and Spanish (S).

1. (E) The approved amount is based on a special payment method.
MSN Code Number 30.1 - REASONABLE CHARGE AND FEE SCHEDULE

   (S) La cantidad aprobada está basada en un método especial de pago.
Mensaje del Resumen de Medicare 30.1 - CARGOS RAZONABLES

2. (E) The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.
MSN Code Number 60.8 - Demonstration Project

   (S) La cantidad aprobada está basada en lo máximo permitido para este artículo bajo el proyecto de Equipo Médico Duradero Protésico, Ortótico y Suministros (DMEPOS, por sus siglas en inglés).
Mensaje del Resumen de Medicare 60.8 - PROJECTO ESPECIAL (DEMOSTRACIONES)

3. (E) The approved amount is based on a special payment method.
MSN Code Number 30.1 - REASONABLE CHARGE AND FEE SCHEDULE

   (S) La cantidad aprobada está basada en un método especial de pago.
Mensaje del Resumen de Medicare 30.1 - CARGOS RAZONABLES

4. (E) Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.
MSN Code Number 60.9 - Demonstration Project

   (S) Nuestros expedientes indican que este paciente empezó el uso de este servicio(s) antes de la ronda actual de Equipo Médico Duradero Protésico, Ortótico y Suministros (DMEPOS, por sus siglas en inglés). Por lo tanto, la cantidad aprobada está basada en la autorización que estaba en efecto antes de la ronda actual para este artículo.
Mensaje del Resumen de Medicare 60.9 - PROJECTO ESPECIAL (DEMOSTRACIONES)

5. (E) This item or service is not covered when performed or ordered by this provider.
MSN Code Number 21.18 - RESTRICTION TO COVERAGE

   (S) Este servicio no está cubierto cuando es ordenado o rendido por este proveedor.
Mensaje del Resumen de Medicare 21.18 - RESTRICCIONES A LA COBERTURA

6. (E) This claim/service is not covered because alternative services were available, and should have been utilized.
MSN Code Number 16.49 – MISCELLANEOUS

(S) Esta reclamación\servicio no está cubierta por que servicios alternativos estaban disponibles, y debieron ser utilizados.
Mensaje del Resumen de Medicare 16.49 – MISCELANEO

7. (E) The approved amount is based on a special payment method.
MSN Code Number 30.1 - REASONABLE CHARGE AND FEE SCHEDULE

(S) La cantidad aprobada está basada en un método especial de pago.
Mensaje del Resumen de Medicare 30.1 - CARGOS RAZONABLES

8. (E) Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided to this patient by a non-demonstration supplier. If you would like more information regarding this project, you may contact 1-888-289-0710.
MSN Code Number 60.10 - Demonstration Project

(S) Aunque este servicio está siendo pagado de acuerdo con las reglas y normas bajo el proyecto de Equipo Médico Duradero Protésico, Ortótico y Suministros (DMEPOS, por sus siglas en inglés), reclamaciones futuras pueden ser denegadas cuando este artículo es suministrado al paciente por un proveedor que no participa en la demonstración. Si usted desea más información referente a este proyecto, puede llamar al 1-888-289-0710.
Mensaje del Resumen de Medicare 60.10 - PROJECTO ESPECIAL (DEMOSTRACIONES)

9. (E) This service not covered unless supplier files an electronic media claim. (EMC).
MSN Code Number 9.9 - FAILURE TO FURNISH INFORMATION

(S) Este servicio no está cubierto a menos de que el suplidor tramite una reclamación de medio electrónico (EMC, por sus siglas en inglés).
Mensaje del Resumen de Medicare 9.9 - FALTA DE INFORMACIÓN SOMETIDA

10. (E) This claim is being processed under a demonstration project. If you would like more information about this project, please contact 1-888-289-0710.
MSN Code Number 60.5 - Demonstration Project

(S) Esta reclamación se está procesando bajo el proyecto de demonstración. Si usted desea más información sobre este proyecto, favor de llamar al 1-888-289-0710.
Mensaje del Resumen de Medicare 60.5 - PROJECTO ESPECIAL (DEMOSTRACIONES)

11. (E) This service/item was billed incorrectly.
MSN Code Number 41.14 - HOME HEALTH MESSAGES (Section 41)

(S) Este servicio o artículo fue facturado incorrectamente.
Mensaje del Resumen de Medicare 41.14 - HHA - AGENCIA DE SERVICIOS DE SALUD EN EL HOGAR

The *effective date* for this Program Memorandum (PM) is January 1, 2001.

The *implementation date* for this PM is January 1, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 31, 2002.

If you have any questions, contact Mark Wynn at (410) 786-6583.