DME Medicare News

DMERC Region A Service Office ❖ P. O. Box 6800 ❖ Wilkes-Barre, PA 18773-6800

No. 14 METRAHEALTH December, 1994

Season's Greetings from the Region A DMERC

Contents

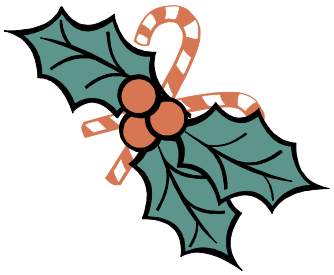
Contacts

DME Region A Service Office
The Travelers Insurance Group . . . . . (717) 735-9400
- FAX . . . . . (717) 735-9402

Beneficiary Toll-Free Number . . . . . (800) 842-2052
Bulletin Board
- Participating Suppliers . . . . . (800) 842-5713
- Non-Participating Suppliers . . . . . (717) 735-9515

EMC FAX . . . . . (717) 735-9510
National Supplier Clearinghouse . . . . . (803) 754-3951
Supplier Number . . . . . (717) 735-9445

The staff of the Region A DMERC wishes to extend Season's Greetings to all suppliers. May you have a happy and prosperous new year.



Announcing ...

The Medicare division of The Travelers will soon become the Medicare division of MetraHealth Companies. You will start to see and hear that name in communications from us. There will be no change in our locations, telephone numbers or people you deal with in our offices.

The Region A "DME Medicare News" is published by The Travelers Government Operations DMERC Professional Relations Unit for DMEPOS suppliers in Region A. For further information on this publication, please contact:

LMN
Region A DMERC
Professional Relations - Outreach
P. O. Box 6800
Wilkes-Barre, PA 18773-6800

Joanne Quaglia, Editor (717) 735-9405

Medical Policy

Subject: Epoetin

HCPCS Codes

Q9920	Injection of EPO, per 1,000 units, at patient Hct of 20 or less
Q9921	Injection of EPO, per 1,000 units, at patient Hct of 21
Q9922	Injection of EPO, per 1,000 units, at patient Hct of 22
Q9923	Injection of EPO, per 1,000 units, at patient Hct of 23
Q9924	Injection of EPO, per 1,000 units, at patient Hct of 24
Q9925	Injection of EPO, per 1,000 units, at patient Hct of 25
Q9926	Injection of EPO, per 1,000 units, at patient Hct of 26
Q9927	Injection of EPO, per 1,000 units, at patient Hct of 27
Q9928	Injection of EPO, per 1,000 units, at patient Hct of 28
Q9929	Injection of EPO, per 1,000 units, at patient Hct of 29
Q9930	Injection of EPO, per 1,000 units, at patient Hct of 30
Q9931	Injection of EPO, per 1,000 units, at patient Hct of 31
Q9932	Injection of EPO, per 1,000 units, at patient Hct of 32
Q9933	Injection of EPO, per 1,000 units, at patient Hct of 33
Q9934	Injection of EPO, per 1,000 units, at patient Hct of 34
Q9935	Injection of EPO, per 1,000 units, at patient Hct of 35
Q9936	Injection of EPO, per 1,000 units, at patient Hct of 36
Q9937	Injection of EPO, per 1,000 units, at patient Hct of 37
Q9938	Injection of EPO, per 1,000 units, at patient Hct of 38
Q9939	Injection of EPO, per 1,000 units, at patient Hct of 39
Q9940	Injection of EPO, per 1,000 units, at patient Hct of 40 or above

Benefit Category: Epoetin for Dialysis Patients

Coverage and Payment Rules

Epoetin (EPO) and items related to its administration are covered by the DMERC when **all** of the following criteria are met:

1) The patient is on Method II home dialysis.

2) The patient has anemia due to chronic renal failure.

3) The EPO is self administered in the home by the patient (or patient caregiver) who is determined competent to use the drug.

4) Prior to initiation of home EPO therapy, the dialysis facility, or the physician responsible for all dialysis-related services furnished to the patient, has made a comprehensive assessment that includes the following:

   a) Measurement of the patient's hematocrit (or hemoglobin), serum iron, transferrin saturation, serum ferritin, and blood pressure,

   b) Assurance that the patient or a caregiver who assists the patient is:

      (i) trained by the facility to inject EPO and is capable of carrying out the procedure,

      (ii) capable of reading and understanding the drug labeling, and

      (iii) trained in, and capable of observing, aseptic techniques,

c) Assurance that the EPO can be stored in the patient's residence under refrigeration and that the patient is aware of the potential hazard of a child's having access to the drug and syringes.

5) For a patient who is initiating EPO treatment, the most recent hematocrit (Hct.) prior to treatment is no higher than 30%, or

   For a patient who has been receiving EPO from a dialysis facility or a physician, the most recent hematocrit prior to initiation of home EPO is between 30-33%.

6) The patient is under the care of a renal dialysis facility which has established a current care plan (a copy of which must be maintained by the designated back-up facility for Method II patients) for monitoring home use of EPO which includes the following:

   a) Review of diet and fluid intake for aberrations as indicated by hyperkalemia and elevated blood pressure secondary to volume overload;

   b) Review of medications to ensure adequate provision of supplemental iron;

   c) Ongoing evaluations of hematocrit and iron stores;

   d) Reevaluation of the dialysis prescription taking into account the patient's increased appetite and red blood cell volume;

   e) A method for the physician and facility (including back-up facility for Method II patients) to follow-up on blood tests and a mechanism (such as a patient log) for keeping the physician informed of the results;

   f) Training of the patient to identify the signs and symptoms of hypotension and hypertension; and

   g) The decrease or discontinuance of EPO if hypertension is uncontrollable.

7) The patient is under the care of a physician who is responsible for all dialysis-related services and who prescribes the EPO and follows the drug labelling instructions when monitoring the EPO home therapy.

8) The patient's physician or dialysis facility develops a protocol that follows the drug label instructions, makes the protocol available to the patient to ensure safe and effective home use of EPO, and maintains adequate records to allow quality assurance for review by the Network and State Survey agencies. (For Method II patients, current records must be provided to and maintained by the designated back-up facility.)

For a patient who is initiating EPO treatment and whose pretreatment hematocrit is higher than 30% (or hemoglobin is higher than 10 gm %), EPO will be covered if additional medical documentation establishes medical necessity in the individual case. For example, patients with severe angina, severe pulmonary distress, or severe hypotension may require EPO to prevent adverse symptoms even if they have higher hematocrit or hemoglobin levels.

The patient's dialysis physician or facility must maintain a flow sheet or log recording the dates and results of hematocrit tests, iron studies, and the EPO prescription with dates of change.

In most patients, the EPO dose and administration scheduled is adjusted to maintain the patient's hematocrit between 30-33%. The medical necessity for maintaining the hematocrit higher than 33% must be documented in the patient's medical record and may be requested by the DMERC.

Supplies (e.g. syringe, needle, alcohol) used for the administration of EPO are included in the allowance for the EPO. These supplies should not be billed separately.

The EPO must be supplied by the Method II supplier of home dialysis equipment and supplies. The amount of EPO that the patient has on hand must be limited to a two-month supply by the amount prescribed by the physician and / or the amount dispensed by the facility.

Only EPO self-administered by Method II home dialysis patients (or their caregiver) is billed to the DMERC. EPO provided in other situations (e.g. in a dialysis facility, in a physician's office, self-administered at home by a center dialysis patient or Method I home dialysis patient, etc.) is billed to the Medicare intermediary or local carrier.

Coding Guidelines

The correct EPO code to use is the one which indicates the patient's most recent hematocrit or hemoglobin (rounded to the nearest whole percent) prior to the date of service of the EPO. For example, if the patient's most recent hematocrit was 20.5%, bill Q9921; if it was 28.4%, bill Q9928.

To convert actual hemoglobin (Hgb.) to corresponding Hct. for Q code reporting, multiply the Hgb value by 3 and round to the nearest whole number. For example, if Hgb = 8.4, report as Q9925 (8.4 X 3 = 25.2, rounded down to 25).

One unit of service of EPO is reported for each 1000 units dispensed. For example if 20,000 units are dispensed, bill 20 units. If the dose dispensed is not an even multiple of 1,000, rounded down for 1-499 units (e.g. 20,400 units dispensed = 20 units billed), round up for 500-999 units (e.g. 20,500 units dispensed = 21 units billed).

Documentation

A prescription (order) for the EPO which has been signed and dated by the ordering physician must be kept on file by the supplier. The prescription must indicate the dose and frequency of administration. A new prescription would be needed if there were a change in the dose or frequency of administration.

The initial claim for EPO must include the date of the patient's most recent hematocrit and/or hemoglobin prior to the initiation of EPO (i.e. the test that was used to determine the code). It must also include the prescribed EPO dosage in units/kg and the patient's weight in kg. If the claim is filed hardcopy, this information would be submitted on a separate sheet attached to the claim. If the claim is filed electronically, it would be transcribed into the HAO record. (See DMEPOS National Standard Format Matrix for details.)

On the initial claim for EPO, a ZX modifier should be added to the EPO code if all coverage criteria (#1-8) listed in the policy are met. (ZX is a new modifier which indicates "The specified coverage criteria in the medical policy have been met and documentation is available in the supplier's records.") If the hematocrit prior to initiation of EPO therapy is greater than or equal to 30%, or if other coverage criteria are not met, the ZX modifier may not be used and the initial claim must be accompanied by a detailed justification of the medical necessity in that patient.

On subsequent claims for EPO, the EJ modifier must be added to the Q code to identify claims which do not require as much information on initial claims. The ZX modifier should not be used on subsequent claims.

On subsequent claims, if the DMERC requests additional information for patients with hematocrits in excess of 33%, then if the goal is to maintain the hematocrit at greater than 33%, the physician/supplier should send in documentation (diagnosis, patient symptoms, etc.) supporting the medical necessity; if the goal is to maintain the Hct. at less than 33%, the physician/supplier should send a copy of the flow sheet for the past 3 months documenting Hct. dates and dates of EPO prescription change.

Refer to the Documentation section of the Supplier Manual for more information on orders, medical records, and supplier documentation.

Effective Date: Coverage and Payment Rules are effective for claims received by the DMERC on or after 10/1/93. Use of the ZX modifier is required for initial claims received by the DMERC on or after March 1, 1995.

Change in Implementation Date

The following are the changes to the date for the implementation of the requirement that physicians complete DME CMNs. These changes affect all suppliers of durable medical equipment, prosthetics, orthotics and supplies in all DMERC regions.

HCFA has extended the deferment of the requirement that physicians complete the medical portion for most DME CMNs. For dates of service prior to October 1, 1995, physicians still must review and sign all CMNs, but do not have to complete the medical portion of the CMN. HCFA is working with physician and supplier associations to develop a process that meets the requirements of the law while keeping burden to a minimum. Effective with the dates of services of October 1, 1995, physicians must complete the medical portion in addition to signing the CMN, unless an alternative process has been selected.

Note

This does not apply to the physician completion of CMNs for the following six (6) items:

Transcutaneous electrical nerve stimulators, powered operated vehicles, air fluidized beds, alternating pressure pads and mattresses, seat lift mechanisms and oxygen (HCFA 484). CMNs for these items will continue to be completed and signed by the physician.

In addition, effective December 1, 1994, physicians will now be required to complete and sign a CMN for lymphedema pumps.

Silicone Pessaries

When silicone pessaries are ordered or dispensed by the physician, as opposed to the older less pliable rubber/plastic type pessaries (A4560), the claim should be submitted using the Not-Otherwise-Classified code, (NOC) A4649. A full narrative description, including manufacturer, should also be entered on the claim. These will be individually priced.

Subject: Lower Limb Prostheses

HCPCS Codes

L5000 Partial Foot, Shoe Insert with Longitudinal Arch, Toe Filler

L5010 Partial Foot, Molded Socket, Ankle Height, with Toe Filler

L5020 Partial Foot, Molded Socket, Tibial Tubercle Height, with Toe Filler

L5050 Ankle, Symes, Molded Socket, Sach Foot

L5060 Ankle, Symes, Metal Frame, Molded Leather Socket, Articulated Ankle/Foot

L5100 Below Knee, Molded Socket, Shin, Sach Foot

L5105 Below Knee, Plastic Socket, Joints and Thigh Lacer, Sach Foot

L5150 Knee Disarticulation (or Through Knee), Molded Socket, External Knee Joints, Shin, Sach Foot

L5160 Knee Disarticulation (or Through Knee), Molded Socket, Bent Knee Configuration, External Knee Joints, Shin, Sach Foot

L5200 Above Knee, Molded Socket, Single Axis Constant Friction Knee, Shin, Each Foot

L5210 Above Knee, Short Prosthesis, No Knee Joint ("Stubbies"), with Foot Blocks, No Ankle Joints, Each

L5220 Above Knee, Short Prosthesis, No Knee Joint ("stubbies"), with Articulated Ankle/Foot, Dynamically Aligned, Each

L5230 Above Knee, For Proximal Femoral Focal Deficiency, Constant Friction Knee, Shin, Sach Foot

L5250 Hip Disarticulation, Canadian Type; Molded Socket, Hip Joint, Single Axis Constant Friction Knee, Shin, Sach Foot

L5270 Hip Disarticulation, Tilt Table Type; Molded Socket, Locking Hip Joint, Single Axis Constant Friction Knee, Shin, Sach Foot

L5280 Hemipelvectomy, Canadian Type; Molded Socket, Hip Joint, Single Axis Constant Friction Knee, Shin, Sach Foot

L5300 Below Knee, Molded Socket, Sach Foot, Endoskeletal System, Including Soft Cover and Finishing

L5310 Knee Disarticulation (or Through Knee), Molded Socket, Sach Foot Endoskeletal System, Including Soft Cover and Finishing

L5320 Above Knee, Molded Socket, Open End, Sach Foot, Endoskeletal System, Single Axis Knee, Including Soft Cover and Finishing

L5330 Hip Disarticulation, Canadian Type; Molded Socket, Endoskeletal System, Hip Joint, Single Axis Knee, Sach Foot, Including Soft Cover and Finishing

L5340 Hemipelvectomy, Canadian Type; Molded Socket, Endoskeletal System, Hip Joint, Single Axis Knee, Sach Foot, Including Soft Cover and Finishing

L5400 Immediate Post Surgical or Early Fitting, Application of Initial Rigid Dressing, Including Fitting, Alignment, Suspension, and One Cast Change, Below Knee

L5410 Immediate Post Surgical or Early Fitting, Application of Initial Rigid Dressing, Including Fitting, Alignment and Suspension, Below Knee, Each Additional Cast Change and Realignment

L5420 Immediate Post Surgical or Early Fitting, Application of Initial Rigid Dressing, Including Fitting, Alignment and Suspension and One Cast Change "AK" or Knee Disarticulation

L5430 Immediate Post Surgical or Early Fitting, Application of Initial Rigid Dressing, Incl. Fitting, Alignment And Suspension, "AK" or Knee Disarticulation, Each Additional Cast Change and Realignment

L5450 Immediate Post Surgical or Early Fitting, Application of Nonweight Bearing Rigid Dressing, Below Knee

L5460 Immediate Post Surgical or Early Fitting, Application of Nonweight Bearing Rigid Dressing, Above Knee

L5500 Initial, Below Knee "PTB" Type Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Plaster Socket, Direct Formed

L5505 Initial, Above Knee-Knee Disarticulation, Ischial Level Socket, "USMC" or Equal Pylon, No Cover, Sach Foot Plaster Socket, Direct Formed

L5510 Preparatory, Below Knee "PTB" Type Socket, "USMC" Or Equal Pylon, No Cover, Sach Foot, Plaster Socket, Molded to Model

L5520 Preparatory, Below Knee "PTB" Type Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Thermoplastic or Equal, Direct Formed

L5530 Preparatory, Below Knee "PTB" Type Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Thermoplastic or Equal, Molded to Model

L5535 Preparatory, Below Knee "PTB" Type Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Prefabricated, Adjustable Open End Socket

L5540 Preparatory, Below Knee "PTB" Type Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Laminated Socket, Molded to Model

L5560 Preparatory, Above Knee-Knee Disarticulation, Ischial Level Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Plaster Socket, Molded to Model

L5570 Preparatory, Above Knee-Knee Disarticulation, Ischial Level Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Thermoplastic or Equal, Direct Formed

L5580 Preparatory, Above Knee-Knee Disarticulation Ischial Level Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Thermoplastic or Equal, Molded to Model

L5585 Preparatory, Above Knee-Knee Disarticulation, Ischial Level Socket, "USMC" or Equal Pylon, No Cover, Sach Foot, Prefabricated Adjustable Open End Socket

L5590 Preparatory, Above Knee-Knee Disarticulation Ischial Level Socket, "USMC" or Equal Pylon No Cover, Sach Foot, Laminated Socket, Molded to Model

L5595 Preparatory, Hip Disarticulation-Hemipelvectomy, Pylon, No Cover, Sach Foot, Thermoplastic or Equal, Molded to Patient Model

L5600 Preparatory, Hip Disarticulation-Hemipelvectomy, Pylon, No Cover, Sach Foot, Laminated Socket, Molded to Patient Model

L5610 Addition to Lower Extremity, Above Knee, Hydracadence System

L5611 Addition to Lower Extremity Above Knee-Knee Disarticulation, 4 Bar Linkage with Friction Swing Phase Control

L5613 Addition to Lower Extremity, Above Knee-Knee Disarticulation, 4 Bar Linkage, with Hydraulic Swing Phase Control

L5614 Addition to Lower Extremity, Above Knee-Knee Disarticulation, 4 Bar Linkage with Pneumatic Swing Phase Control

L5616 Addition to Lower Extremity, Above Knee, Universal Multiplex System, Friction Swing Phase Control

L5618 Addition to Lower Extremity, Test Socket, Symes

L5620 Addition to Lower Extremity, Test Socket, Below Knee

L5622 Addition to Lower Extremity, Test Socket, Knee Disarticulation

L5624 Addition to Lower Extremity, Test Socket, Above Knee

L5626 Addition to Lower Extremity, Test Socket, Hip Disarticulation

L5628 Addition to Lower Extremity, Test Socket, Hemipelvectomy

L5629 Addition to Lower Extremity, Below Knee, Acrylic Socket

L5630 Addition to Lower Extremity, Symes Type, Expandable Wall Socket

L5631 Addition To Lower Extremity, Above Knee or Knee Disarticulation, Acrylic Socket

L5632 Addition to Lower Extremity, Symes Type, "PTB" Brim Design Socket

L5634 Addition to Lower Extremity, Symes Type, Posterior Opening (Canadian) Socket

L5636 Addition to Lower Extremity, Symes Type, Medial Opening Socket

L5637 Addition to Lower Extremity, Below Knee, Total Contact

L5638 Addition to Lower Extremity, Below Knee, Leather Socket

L5639 Addition to Lower Extremity, Below Knee, Wood Socket

L5640 Addition to Lower Extremity, Knee Disarticulation, Leather Socket

L5642 Addition to Lower Extremity, Above Knee, Leather Socket

L5643 Addition to Lower Extremity, Hip Disarticulation, Flexible Inner Socket, External Frame

L5644 Addition to Lower Extremity, Above Knee, Wood Socket

L5645 Addition to Lower Extremity, Below Knee, Flexible Inner Socket, External Frame

L5646 Addition to Lower Extremity, Below Knee, Air Cushion Socket

L5647 Addition to Lower Extremity, Below Knee Suction Socket

L5648 Addition to Lower Extremity, Above Knee, Air Cushion Socket

L5649 Addition to Lower Extremity, Ischial Containment / Narrow M-L Socket

L5650 Additions to Lower Extremity, Total Contact, Above Knee or Knee Disarticulation Socket

L5651 Addition to Lower Extremity, Above Knee, Flexible Inner Socket, External Frame

L5652 Addition to Lower Extremity, Suction Suspension, Above Knee or Knee Disarticulation Socket

L5653 Addition to Lower Extremity, Knee Disarticulation, Expandable Wall Socket

L5654 Addition to Lower Extremity, Socket Insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or Equal)

L5655 Addition to Lower Extremity, Socket Insert, Below Knee (Kemblo, Pelite, Aliplast, Plastazote or Equal)

L5656 Addition to Lower Extremity, Socket Insert, Knee Disarticulation (Kemblo, Pelite, Aliplast, Plastazote or Equal)

L5658 Addition to Lower Extremity, Socket Insert, Above Knee (Kemblo, Pelite, Aliplast, Plastazote or Equal)

L5660 Addition to Lower Extremity, Socket Insert, Symes, Silicone Gel or Equal

L5661 Addition to Lower Extremity, Socket Insert, Multi-Durometer Symes

L5662 Addition to Lower Extremity, Socket Insert, Below Knee, Silicone Gel or Equal

L5663 Addition to Lower Extremity, Socket Insert, Knee Disarticulation, Silicone Gel or Equal

L5664 Addition to Lower Extremity, Socket Insert, Above Knee, Silicone Gel or Equal

L5665 Addition to Lower Extremity, Socket Insert, Multi-Durometer, Below Knee

L5666 Addition to Lower Extremity, Below Knee, Cuff Suspension

L5667 Addition to Lower Extremity, Below Knee, Socket Insert, Suction Suspension, with Locking Mechanism

L5668 Addition to Lower Extremity, Below Knee, Molded Distal Cushion

L5669 Addition to Lower Extremity, Below Knee, Socket Insert, Suction Suspension without Locking Mechanism

L5670 Addition to Lower Extremity, Below Knee, Molded Supracondylar Suspension (“PTS” or Similar)

L5672 Addition to Lower Extremity, Below Knee, Removable Medial Brim Suspension

L5674 Addition to Lower Extremity, Below Knee, Latex Sleeve Suspension or Equal, Each

L5675 Addition to Lower Extremity, Below Knee, Latex Sleeve Suspension or Equal, Heavy Duty, Each

L5676 Additions to Lower Extremity, Below Knee, Knee Joints, Single Axis, Pair

L5677 Additions to Lower Extremity, Below Knee, Knee Joints, Polycentric, Pair

L5678 Additions to Lower Extremity, Below Knee, Joint Covers, Pair

L5680 Addition to Lower Extremity, Below Knee, Thigh Lacer, Non-molded

L5682 Addition to Lower Extremity, Below Knee, Thigh Lacer, Gluteal/Ischial, Molded

L5684 Addition to Lower Extremity, Below Knee, Fork Strap

L5686 Addition to Lower Extremity, Below Knee, Back Check (Extension Control)

L5688 Addition to Lower Extremity, Below Knee, Waist Belt, Webbing

L5690 Addition to Lower Extremity, Below Knee, Waist Belt, Padded and Lined

L5692 Addition to Lower Extremity, Above Knee, Pelvic Control Belt, Light

L5694 Addition to Lower Extremity, Above Knee, Pelvic Control Belt, Padded and Lined

L5695 Addition to Lower Extremity, Above Knee, Pelvic Control, Sleeve Suspension, Neoprene or Equal, Each

L5696 Addition to Lower Extremity, Above Knee or Knee Disarticulation, Pelvic Joint

L5697 Addition to Lower Extremity, Above Knee or Knee Disarticulation, Pelvic Band

L5698 Addition to Lower Extremity, Above Knee or Knee Disarticulation, Silesian Bandage

L5699 All Lower Extremity Prostheses, Shoulder Harness

L5700 Replacement, Socket, Below Knee, Molded to Patient Model

L5701 Replacement, Socket, Above Knee/Knee Disarticulation Including Attachment Plate, Molded to Patient Model

L5702 Replacement, Socket, Hip Disarticulation, Including Hip Joint, Molded to Patient Model

L5704 Replacement, Custom Shaped Protective Cover, Below Knee

L5705 Replacement, Custom Shaped Protective Cover, Above Knee

L5706 Replacement, Custom Shaped Protective Cover Knee Disarticulation

L5707 Replacement, Custom Shaped Protective Cover Hip Disarticulation

L5710 Addition, Exoskeletal Knee-Shin System, Single Axis, Manual Lock

L5711 Additions Exoskeletal Knee-Shin System, Single Axis, Manual Lock, Ultra-light Material

L5712 Addition, Exoskeletal Knee-Shin System, Single Axis, Friction Swing and Stance Phase Control (Safety Knee)

L5714 Addition, Exoskeletal Knee-Shin System, Single Axis, Variable Friction Swing Phase Control

L5716 Addition, Exoskeletal Knee-Shin System, Polycentric, Mechanical Stance Phase Lock

L5718 Addition, Exoskeletal Knee-Shin System, Polycentric, Friction Swing and Stance Phase Control

L5722 Addition, Exoskeletal Knee-Shin System, Single Axis, Pneumatic Swing, Friction Stance Phase Control

L5724 Addition, Exoskeletal Knee-Shin System, Single Axis, Fluid Swing Phase Control

L5726 Addition, Exoskeletal Knee-Shin System, Single Axis, External Joints Fluid Swing Phase Control

L5728 Addition, Exoskeletal Knee-Shin System, Single Axis, Fluid Swing and Stance Phase Control

L5780 Addition, Exoskeletal Knee-Shin System, Single Axis, Pneumatic/Hydra Pneumatic Swing Phase Control Component Modification

L5785 Addition, Exoskeletal System, Below Knee, Ultra-light Material (Titanium, Carbon Fiber or Equal)

L5790 Addition, Exoskeletal System, Above Knee, Ultra-light Material (Titanium, Carbon Fiber or Equal)

L5795 Addition, Exoskeletal System, Hip Disarticulation, Ultra-light Material (Titanium, Carbon Fiber or Equal)

L5810 Addition, Endoskeletal Knee-Shin System, Single Axis, Manual Lock

L5811 Addition, Endoskeletal Knee-Shin System, Single Axis, Manual Lock, Ultra-light Material

L5812 Addition, Endoskeletal Knee-Shin System, Single Axis, Friction Swing and Stance Phase Control (Safety Knee)

L5816 Addition, Endoskeletal Knee-Shin System, Polycentric, Mechanical Stance Phase Lock

L5818 Addition, Endoskeletal Knee-Shin System, Polycentric, Friction Swing, and Stance Phase Control

L5822 Addition, Endoskeletal Knee-Shin System, Single Axis, Pneumatic Swing, Friction Stance Phase Control

L5824 Addition, Endoskeletal Knee-Shin System, Single Axis, Fluid Swing Phase Control

L5828 Addition, Endoskeletal Knee-Shin System, Single Axis, Fluid Swing and Stance Phase Control

L5830 Addition, Endoskeletal Knee-Shin System, Single Axis, Pneumatic/Swing Phase Control

L5840 Addition, Endoskeletal Knee-Shin System Multiaxial, Pneumatic Swing Phase Control

L5850 Addition, Endoskeletal System, Above Knee Or Hip Disarticulation, Knee Extension Assist

L5855 Addition, Endoskeletal System, Hip Disarticulation, Mechanical Hip Extension Assist

L5910 Addition, Endoskeletal System, Below Knee, Alignable System

L5920 Addition, Endoskeletal System, Above Knee or Hip Disarticulation, Alignable System

L5925 Addition, Endoskeletal System, Above Knee, Knee Disarticulation or Hip Disarticulation, Manual

L5940 Addition, Endoskeletal System, Below Knee, Ultra-light Material (Titanium, Carbon Fiber or Equal)

L5950 Addition, Endoskeletal System, Above Knee, Ultra-light Material (Titanium, Carbon Fiber or Equal)

L5960 Addition, Endoskeletal System, Hip Disarticulation, Ultra-light Material (Titanium, Carbon Fiber or Equal)

L5962 Addition, Endoskeletal System, Below Knee Flexible Protective Outer Surface Covering System

L5964 Addition, Endoskeletal System, Above Knee Flexible Protective Outer Surface Covering System

L5966 Addition, Endoskeletal, System, Hip Disarticulation, Flexible Protective Outer Surface Covering System

L5970 All Lower Extremity Prostheses, Foot, External Keel, Sach Foot

L5972 All Lower Extremity Prostheses, Flexible Keel Foot (Safe, Sten, Bock Dynamic or Equal)

L5974 All Lower Extremity Prostheses, Foot, Single Axis Ankle/Foot

L5976 All Lower Extremity Prostheses, Energy Storing Foot (Seattle Carbon Copy II or Equal)

L5978 All Lower Extremity Prostheses, Foot, Multiaxial Ankle/Foot

L5979 All Lower Extremity Prostheses, Foot, Multiaxial, Ankle/Foot, Dynamic Response

L5980 All Lower Extremity Prostheses, Flex Foot System

L5981 All Lower Extremity Prostheses, Flex-walk System or Equal

L5982 All Exoskeletal Lower Extremity Prostheses, Axial Rotation Unit

L5984 All Endoskeletal Lower Extremity Prostheses, Axial Rotation Unit

L5986 All Lower Extremity Prostheses, Multi-axial Rotation Unit (“MCP” or Equal)

L5999 Unlisted Procedures for Lower Extremity Prosthesis

L7500 Repair of Prosthetic Device, Hourly Rate

L7510 Repair of Prosthetic Device, Repair or Replace Minor Parts

L8400 Prosthetic Sheath, Below Knee, Each

L8410 Prosthetic Sheath, Above Knee, Each

L8420 Prosthetic Sock, Below Knee, Each

L8430 Prosthetic Sock, Above Knee, Each

L8440 Prosthetic Shrinker, Below Knee

L8460 Prosthetic Shrinker, Above Knee

L8470 Stump Sock, Single Ply, Fitting, Below Knee, Each

L8480 Stump Sock, Single Ply, Fitting, Above Knee, Each

L8490 Addition to Prosthetic Sheath / Sock, Air Seal Suction Retention System

K0285 Repair of Prosthetic Device, Labor Component, per 15 Minutes

Level II Modifiers

K0 Lower limb extremity prosthesis functional Level 0 - Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

K1 Lower extremity prosthesis functional Level 1 - Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

K2 Lower extremity prosthesis functional Level 2 - Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stair or uneven surfaces. Typical of the limited community ambulator.

K3 Lower extremity prosthesis functional Level 3 - Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

K4 Lower extremity prosthesis functional Level 4 - Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Benefits Category: Prosthetic Devices

Definitions

A **functional level** is a measurement of the capacity and potential of the patient to accomplish his / her expected, post-rehabilitation, daily function. The functional classification is used by the DMERC to establish the medical necessity only of prosthetic knees, feet and ankles.

An **adjustment** is any modification to the prosthesis due to a change in the patient's condition or to improve the function of the prosthesis.

A **repair** is a restoration of the prosthesis to correct problems due to wear or damage.

A **replacement** is the removal and substitution of a component of a prosthesis that has a HCPCS definition.

Coverage and Payment Rules

A lower limb prosthesis is covered when the patient:

1) Will reach or maintain a defined functional state within a reasonable period of time; *and*

2) Is motivated to ambulate

Functional Levels

A determination of the medical necessity for certain components / additions to the prosthesis is based on the patient's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and ordering physician, considering factors including, but not limited to:

a. The patient's past history (including prior prosthetic use if applicable)

b. The patient's current condition including the status of the residual limb and the nature of other medical problems and

c. the patient's desire to ambulate.

Clinical assessments of patient rehabilitation potential should be based on the following classification levels:

Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

Level 1: Has the ability or potential to use a prosthesis for transfers or ambulation on level sur-

faces at fixed cadence. Typical of the limited and unlimited household ambulator.

Level 2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.

Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

The records should document the patient's current functional capabilities and his / her expected functional potential, including an explanation for the difference, if that is the case. The DMERC recognizes within the functional classification hierarchy that bilateral amputees often cannot be strictly bound by functional level classifications.

General

Prostheses are covered when furnished incident to physicians' services or on a physician's order. Accessories (e.g. stump stockings for the residual limb, harness [including replacements]) are also covered when these appliances aid in or are essential to the effective use of the artificial limb.

The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable to Medicare under the prosthetic benefit:

- ❑ Evaluation of the residual limb and gait
- ❑ Fitting of the prosthesis
- ❑ Cost of base component parts and labor contained in HCPCS base codes
- ❑ Repairs due to normal wear or tear within 90 days of delivery
- ❑ Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments **are not** necessitated by changes in the residual limb or the patient's functional abilities.

Any prosthesis or prosthetic component provided in an inpatient hospital setting should not be submitted to the DMERC.

When an initial below knee prosthesis (L5500) or a preparatory below knee prosthesis (L5510-L5530, L5540) is provided, prosthetic substitutions and / or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5629, L5638, L5639, L5646, L5647, L5667, L5669, L5785, L5962, and L5980 which will be denied as not medically necessary. When a below knee preparatory prefabricated prosthesis (L5535) is provided prosthetic substitutions and / or additions of procedures are covered in accordance with the functional level assessment except for codes L5620, L5629, L5645, L5646, L5667, L5669, L5670, and L5676 which will be denied as not medically necessary.

When an above knee initial prosthesis (L5505) or an above knee preparatory (L5560-L5580, L5590-L5600) prosthesis is provided, prosthetic substitution and / or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5610, L5631, L5640, L5642, L5644, L5648, L5980, and L5710-L5780, L5790-L5795 which will be denied as not medically necessary. When an above knee preparatory prefabricated prosthesis (L5585) is provided, prosthetic substitution and / or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5624, L5631, L5648, L5651, L5652, L5964, and L5966 which will be denied as not medically necessary.

In the following sections, the determination of coverage for selected prostheses and components with respect to potential functional levels represents the usual case. Exceptions will be considered in an individual case if additional documentation is included which justifies the medical necessity. Prostheses will be denied as not medically necessary if the patient's potential functional level is "0".

Feet

A determination of the type of foot for the prosthesis will be made by the prescribing physician and / or the prosthetist based upon the functional needs of the patient. Basic lower extremity prostheses include a SACH foot. Prosthetic feet are considered for coverage based upon functional classification.

- ❑ External keel, SACH foot (L5970) or single axis ankle / foot (L5974) are covered for patients with a functional **Level 1** or above.
- ❑ Flexible-keel foot (L5972) and multiaxial ankle / foot (L5978) candidates are expected to demonstrate a functional **Level 2** or greater functional needs.

- ❑ Flex foot system (L5980), energy storing foot (L5976), multiaxial ankle/foot, dynamic response (L5979), or flex-walk system or equal (L5981) are covered for patients with a functional **Level 3** or above.

Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of foot. This information must be retained in the physician's or prosthetist's files.

Knees

A determination of the type of knee for the prosthesis will be made by the prescribing physician and/or the prosthetist based upon the functional needs of the patient. Basic lower extremity prostheses include a single axis, constant friction knee. Prosthetic knees are considered for coverage based upon functional classsification.

- ❑ Fluid and pneumatic knees (L5610 - L5616, L5722 - L5780, L5822 - L5840) are covered for patients with a functional **Level 3** or above.
- ❑ Other knee-shin systems (L5710-L5718, L5810-L5818) are covered for patients with a functional **Level 1** or above.

Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic design feature of a given type of knee. This information must be retained in the physician's or prosthetist's files.

Ankles

Axial rotation units (L5982 - L5986) are covered for patients with a functional Level 2 or above.

Sockets

Test (diagnostic) sockets for Immediate (L5400 - L5460) prostheses are not medical necessary.

No more than 2 test (diagnostic) sockets for an individual prosthesis are medically necessary without additional documentation.

No more than two of the same socket inserts (L5654 - L5665) are allowed per individual prosthesis at the same time.

Socket replacements are considered medically necessary if there is adequate documentation of functional and/or physiological need. The DMERC recognizes that there are situations where the explanation includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.

Adjustment, Repairs, and Component Replacement

Routine periodic servicing, such as testing, cleaning, and checking of the prosthesis, is noncovered. Adjustments to a prosthesis required by wear or by change in the patient's condition are covered under the initial physician's order for the prosthesis for the life of the prosthesis.

Repairs to a prosthesis are covered when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payments can be made for the amount of the excess. Maintenance which may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist is covered as a repair.

Replacement of a prosthesis or prosthetic component is covered in cases of loss or irreparable damage or wear or when required because of a change in the patient's condition. Expenses for replacement of a prosthesis or prosthetic components required because of loss or irreparable damage may be reimbursed without a physician's order when it is determined that the prosthesis as originally ordered still fills the patient's medical needs. However, claims involving replacement of a prosthesis or major component (foot, ankle, knee, socket) necessitated by wear or a change in the patient's condition must be supported by a new physician's order. When the DMERC determines that malicious damage, culpable neglect or wrongful disposition of the prosthesis has occured, investigation will be undertaken to determine whether it is unreasonable to make program payment under the circumstances.

Coding Guidelines

Adjustments and **repairs** are billed as a labor charge using HCPCS code K0285 (one unit of service representing 15 minutes of labor time). Documentation should exist in the supplier's records indicating the precise adjustments and/or repairs performed and actual time involved. The time reported for K0285 should only be for laboratory repair time and associated prosthetic evaluation. Evaluation not associated with repair or adjustment is noncovered and should not be coded with K0285. The time for patient evaluation, gait instruction, and other general education should not be reported with code K0285. Code L7500 is not valid for billing claims to the DMERC.

The L7510 code is used to bill for any "minor" materials (those without HCPCS definitions) used to achieve the adjustment and/or repair.

Replacement of components (except sockets and covers) are billed using the base code for the component

with the addition of the **RP** modifier. Socket and cover replacement procedures are identified by the codes L5700 to L5707. Since these codes are defined as a replacement, the modifier **RP** should not be used. The submitted charge for replacements reflects both the cost of the component and the labor associated with the removal, replacement, and finishing of that component. Labor associated with replacement should not be reported using code K0285.

The right (RT) and left (LT) modifiers should be used with prosthesis codes. When the same code for prostheses, sockets, or components for bilateral amputees are billed on the same date of service, the items (RT and LT) will be entered on the same line of the claim using the LTRT modifier and billed with 2 units of service.

Documentation

An order for the prosthesis including all components which is signed and dated by the ordering physician must be kept on file by the prosthetist. Adjustments and repairs of prostheses and prosthetic components are covered under this original order. Claims involving replacement of a prosthesis or major component (foot, ankle, knee, socket) necessitated by wear or a change in the patient's condition must be supported by a new physician's order. If replacement of a prosthesis or prosthetic component is required because of loss or irreparable damage, reimbursement may be made without a new physician's order if it is determined that the prosthesis as originally ordered, considering the time since it was furnished, still fills the patient's medical need.

The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary.

When replacement of the entire prosthesis or socket is billed, the claim must be accompanied by an explanation of the medical necessity of the replacement. The DMERC recognizes that there are situations where the explanation includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear / tear due to excessive patient weight or prosthetic demands of very active amputees.

When submitting a prosthetic claim to the DMERC, the billed code for knees, feet and ankle (HCPCS codes L5610 - L5616, L5710 - L5780, L5810 - L5840, L5970 - L5981) components must be submitted with modifiers K0 - K4, indicating the expected patient functional level. This expectation of functional ability information must be clearly documented and retained in the prosthetist's records.

Effective Date

Claims received by the DMERC on or after March 1, 1995.

Therapeutic Shoes: New Codes After January 1, 1995

The DMERC medical policy on Therapeutic Shoes for Diabetics published in this bulletin uses the newly established A series HCPCS codes, A5500-A5507. These codes are to be used only for claims with dates of services on or after January 1, 1995. The Q series HCPCS codes, Q0117-Q0123 and Q0133, must be used for claims with dates of service on or before December 31, 1994. These Q codes may also be used during a grace period defined as dates of service from January 1, 1995, to March 31, 1995. If these Q codes are billed for dates of service on or after April 1, 1995, they will be denied as invalid codes.

Subject: Therapeutic Shoes for Diabetics

HCPCS Codes

A5500 For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe

A5501 For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe

A5502 For diabetics only, multiple density insert(s), per shoe

A5503 For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe

A5504 For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe

A5505 For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or

custom-molded shoe with metatarsal bar, per shoe

A5506 For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe

A5507 For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay or custom-molded shoe, per shoe

L3649 Unlisted procedures for foot orthopedic shoes, shoe modifications and transfers

Benefit Category: Therapeutic Shoes for Diabetics

Definitions

A depth shoe (A5500) is one that 1) has a full length, heel-to-toe filler that when removed provides a minimum of 3/16" of additional depth used to accommodate custom-molded or customized inserts, 2) is made from leather or other suitable material of equal quality, 3) has some form of shoe closure, and 4) is available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoe according to the American standard last sizing schedule or its equivalent. (The American last sizing schedule is the numerical shoe sizing system used for shoes in the United States.) This includes a shoe with or without an internally seamless toe.

A custom-molded shoe (A5501) is one that 1) is constructed over a positive model of the patient's foot, 2) is made from leather or other suitable material of equal quality, 3) has removable inserts that can be altered or replaced as the patient's condition warrants, and 4) has some form of shoe closure. This includes a shoe with or without an internally seamless toe.

An insert (A5502) is a total contact, multiple density, removable inlay that is directly molded to the patient's foot or a model of the patient's foot and that is made of a suitable material with regard to the patient's condition.

Rigid rocker bottoms (A5503) are exterior elevations with apex position for 51 percent to 75 percent distance measured from the back end of the heel. The apex is a narrowed or pointed end of an anatomical structure. The apex must be positioned behind the metatarsal heads and tapering off sharply to the front tip of the sole. Apex height helps to eliminate pressure at the metatarsal heads. Rigidity is ensured by the steel in the shoe. The heel of the shoe tapers off in the back in order to cause the heel to strike in the middle of the heel.

Roller bottoms (sole or bar) (A5503) are the same as rocker bottoms, but the heel is tapered from the apex to the front tip of the sole.

Wedges (posting) (A5504) are either of hind foot, fore foot, or both and may be in the middle or to the side. The function is to shift or transfer weight bearing upon standing or during ambulation to the opposite side for added support, stabilization, equalized weight distribution, or balance.

Metatarsal bars (A5505) are exterior bars which are placed behind the metatarsal heads in order to remove pressure from the metatarsal heads. The bars are of various shapes, heights, and construction depending on the exact purpose.

Offset heel (A5506) is a heel flanged at its base either in the middle, to the side, or a combination, that is then extended upward to the shoe in order to stabilize extreme positions of the hind foot.

Coverage and Payment Rules

Diabetic shoes, inserts and/or modifications to the shoes are covered if the following criteria are met:

1) The patient has diabetes mellitus (ICD-9 diagnosis codes 250.00-250.91); and

2) The patient has one or more of the following conditions:

   a) Previous amputation of the other foot, or part of either foot, or

   b) History of previous foot ulceration of either foot, or

   c) History of pre-ulcerative calluses of either foot, or

   d) Peripheral neuropathy with evidence of callus formation of either foot, or

   e) Foot deformity of either foot, or

   f) Poor circulation in either foot; and

3) The physician who is managing the patient's systemic diabetes condition has certified that indications 1 and 2 are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.

For patients meeting these criteria, coverage is limited to one of the following within one calendar year:

1) One pair of custom molded shoes (A5501) (which includes inserts provided with these shoes) and 2 additional pairs of inserts (A5502); or

2) One pair of depth shoes (A5500) and 3 pairs of inserts (A5502) (not including the non-customized removable inserts provided with such shoes).

Separate inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in this policy for depth shoes or custom-molded shoes. In addition, the inserts furnished must fully meet the definition of an insert set forth in this policy. Inserts which will be used in noncovered shoes are noncovered.

A custom molded shoe (A5501) is covered when the patient has a foot deformity which cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the supplier's records and may be requested by the DMERC. If there is insufficient justification for a custom molded shoe but the general coverage criteria are met, payment will be based on the allowance for the least costly medically appropriate alternative, A5500.

A modification of a custom molded or depth shoe will be covered as a substitute for an insert. Although not intended as a comprehensive list, the following are the most common shoe modifications: rigid rocker bottoms (A5503), roller bottoms (A5503), wedges (A5504), metatarsal bars (A5505), or offset heels (A5506). Other modifications to diabetic shoes (A5507) include, but are not limited to flared heels and inserts for missing toes.

Deluxe upgrades to diabetic shoes, including but not limited to style, color, or type of leather, will be denied as not medically necessary.

Shoes, inserts, and/or modifications that are provided to patients who do not meet the coverage criteria will be denied as noncovered. When codes are billed without a ZX modifier (see Documentation section), they will be denied as noncovered.

The particular type of footwear (shoes, inserts, modifications) which is necessary must be prescribed by a podiatrist or other qualified physician, knowledgeable in the fitting of diabetic shoes and inserts. The footwear must be fitted and furnished by a podiatrist or other qualified individual such as a pedorthist, orthotist or prosthetist. The certifying physician (i.e. the physician who manages the systemic diabetic condition) may not furnish the footwear unless he/she practices in a defined rural area or a defined health professional shortage area. The prescribing physician (podiatrist or other qualified physician) can be the supplier (i.e. the one who furnishes the footwear).

There is no separate payment for the fitting of the shoes, inserts or modifications or for the certification of need or prescription of the footwear. Unrelated evaluation and management services by the physician are processed by the local carrier.

Coding Guidelines

Code A5507 is only to be used for not otherwise specified therapeutic modifications to the shoe. Code A5507 is not to be used for deluxe upgrades to diabetic shoes. At this time, deluxe features should be coded using code L3649. A new HCPCS code will be established for deluxe features and will be published separately with its effective date.

A codes for inserts or modifications (A5502-A5506, A5507) may only be used for items related to diabetic shoes (A5500, A5501). They should not be used for items related to footwear coded with codes L3215-L3253. Inserts and modifications used with L coded footwear should be coded using L codes (L3000-L3649).

When a single shoe, insert or modification is provided, the appropriate modifier, right (RT) or left (LT), should be used. If a pair is provided, report as two (2) units of service on the claim - the RT or LT modifiers should not be used.

Documentation

An order for the shoes, inserts or modifications which has been signed and dated by the prescribing physician must be kept on file by the supplier. If the prescribing physician is the supplier, a separate order is not required, but the item provided must be clearly noted in the patient's record. A new order is not required for the replacement of an insert or modification within one year of the order on file. However the supplier's records should document the reason for the replacement. A new order is required for the replacement of any shoe. A new order is also required for the replacement of an insert or modification more than one year from the most recent order on file.

The supplier should obtain a signed statement from the certifying physician specifying that the patient has diabetes mellitus, has one of conditions 2a-2f listed in the policy, is being treated under a comprehensive plan of care for his/her diabetes, and needs diabetic shoes. The Statement of Certifying Physician for Therapeutic Shoes

developed by the DMERC is recommended. This statement may be completed by the prescribing physician or supplier but must be reviewed for accuracy of the information and signed by the certifying physician to indicate agreement. A new Certification Statement would be required for a shoe, insert or modification provided more than one year from the most recent Certification Statement on file. If the supplier has a current signed statement on file that indicates that the coverage criteria described above have been met, then a ZX modifier should be added to the code. (ZX is a new modifier which indicates "The specified coverage criteria in the medical policy have been met and documentation is available in the supplier's records".) A diagnosis code for diabetes should be entered on the claim.

On hard copy claims, this statement should be on a separate sheet attached to the claim. On electronic claims, it would be put in the HAO record.

If code A5507 or L3649 is submitted, the claim must contain a narrative description of the modification or feature provided.

The prescribing physician's name and UPIN number should be listed in Blocks 17 and 17a of the HCFA 1500 form or the electronic equivalent.

Effective Date

Coverage and Payment Rules are effective for claims with dates of service on or after May 1, 1993 received by the DMERC. Use of the ZX modifier is required for claims received by the DMERC on or after March 1, 1995.

Statement of Certifying Physician for Therapeutic Shoes

Patient name: _____

HIC #: _____

I certify that all of the following statements are true:

1) This patient has diabetes mellitus.

2) This patient has one or more of the following conditions (circle all that apply):

   a) History of partial or complete amputation of the foot
   b) History of previous foot ulceration
   c) History of pre-ulcerative callus
   d) Peripheral neuropathy with evidence of callus formation
   e) Foot deformity
   f) Poor circulation

3) I am treating this patient under a comprehensive plan of care for his / her diabetes.

4) This patient needs special shoes (depth or custom-molded shoes) because of his / her diabetes.

Physician signature: _____

Date signed: _____

Physician name (printed): _____

Physician address: _____

_____

_____

Electronic Media Claims

Contacting the EMC Team

If you need assistance from the EMC unit, you may contact the EMC Help Desk at one of the following numbers:

(717) 735-9519 (717) 735-9527

(717) 735-9528 (717) 735-9532

The Bulletin Board System

The Bulletin Board System is used not only for the submission of claims, but also for the EMC unit to leave messages for submitters regarding any updates, changes or revisions on electronic issues, medical policies, or newsletter updates. These messages are a vital tool for keeping suppliers updated on all issues. Please read these messages when dialing into the Bulletin Board System.

Non-participating suppliers: (717)735-9515

Participating suppliers: (800)842-5713

New Free Software Print Package

The Travelers EMC Unit will be providing a free software print package to all EMC submitters. This print package will print the new electronic file acknowledgment into a readable report, not the old flat 4000 file record. This software package can be downloaded from The Travelers Bulletin Board. The software will be located in menu pick G "System Support Files." This menu pick will contain the following information:

- ❑ File format explanation
- ❑ Error code explanation
- ❑ Print package software
- ❑ Explanation of print package software

The file format explanation document is approximately seven pages in length. The error code explanation documentation is approximately 45 pages in length.

Edit Error Messages

Claim records received electronically are edited to ensure the record is formatted correctly, required fields are present, and acceptable values and codes are used. Claim records containing errors are rejected with an explanatory error code. A description of error codes is available on our Bulletin Board. Rejected claims do not enter the system and must be corrected and resubmitted.

Claim records which pass these "front-end" edits enter our system and receive further editing and may suspend for manual review and development for a variety of reasons, including medical or utilization, secondary payor, pricing, etc. The suspension of any claim record for these reasons occurs after the electronic acknowledgment has been created and is not reflected on the acknowledgment.

EMC Billing Reminders

1. Make sure to use zeros in the submitter number and not the alpha character *o*. The system will reject the claim if it is not correct (e.g., a08000001).

2. The beneficiary's Health Insurance Claim (HIC) number must be properly constructed. Use the correct amount of numeric characters and alpha characters for each number. There should not be any spaces in the HIC number.

3. The physicians full name and UPIN Number must be indicated on all claims. The first name must be at least two letters (NSF - FB1 6, FB1 7, FB1 9).

4. If secondary insurance information is included on the claim and it is a Medigap policy, the OCNA Number (Other Carrier Name and Address) must be entered (NSF - DA07). If the insurance is a supplemental policy, an OCNA Number is not required. An OCNA Number listing can be found on page 4-21 of the *Supplier Manual.*

5. If a Certificate of Medical Necessity is sent in with the claim, the initial date of need must be filled in with a valid date (NSF- GU0 19).

6. If there is a change to the current CMN or a recertification is due, the dates of these must be included on the CMN (NSF - GU0 20). If it is not a revised or recertification, this field can be blank.

7. The date of last medical examination is required on the CMN (NSF - GU0 18).

8. The entire 10-digit NSC Number must be included on every claim (FA023). The biller code must be the first 6 digits of the NSC Number (BA0, 02, 09, YA0, 02).

9. Always refer to the HCPCS procedure code when billing number of services (e.g., Lancets 1 box of 50 = 1 Number of Service.)

Zipped Files

The Travelers EMC Unit can now accept production files which are sent in a zipped format. This allows for multiple files to be sent at once and also cuts down on transmission time. For more information on zipped files, please contact the EMC Unit at 717-735-9521 or 717-735-9530.

Electronic Claim Acknowledgment

Each time Travelers successfully receives a file, an acknowledgment will be returned to the submitter. The acknowledgment will contain submitter identification, as well as specific detail information regarding the receipt and acceptance of electronic claims. It will identify the number of claims and charges submitted, accepted, and rejected. In addition, edit error messages will be included whenever a problem is encountered with the records in the transmission.

Each confirmation record contains a total of 4000 characters, and up to 20 edit messages can be returned per record. In most instances, only one acknowledgment record will be returned to the submitter. However, if more than 20 edit messages are generated, more than one record will be sent.

Effective December 20, 1994, the electronic file acknowledgment specifications will be changed to the following:

Record Layout

01	Submitter ID	PIC X(16)
02	Process Date	PIC X(06)
03	Process Time	PIC X(08)
04	Filler	PIC X(06)
05	Carrier Number	PIC X(05)
06	Submitter Code	PIC X(16)
07	Submission Number	PIC X(06)
08	Submitter Create Date	PIC X(08)
09	Submitter Time	PIC X(08)
10	Test / Prod Indicator	PIC X(04)
11	Record Sequence Number	PIC 9(03)
12	Region Indicator	PIC X(02)
13	EMC Medium	PIC X(01)
14	Charges Submitted	PIC 9(09)V99
15	Claims Submitted	PIC 9(09)
16	Charges Accepted	PIC 9(09)V99
17	Claims Accepted	PIC 9(09)
18	Charges Rejected	PIC 9(09)V99
19	Claims Rejected	PIC 9(09)
20	EMC Contact	PIC X(40)
21	EMC Contact Phone Number	PIC X(10)
22	Filler	PIC X(151)

The following data items occur 20 times:

23	Insured ID Number	PIC X(12)
24	Patient Control Number	PIC X(17)
2S	Line Item Control Number	PIC X(17)
26	EMC Provider ID	PIC X(15)
27	Batch Number	PIC X(04)
28	Batch ID	PIC X(06)
29	Provider Number	PIC X(15)
30	Sequence Number	PIC X(06)
31	Line Number	PIC X(03)
32	Claim ID Number	PIC X(06)
33	Service Line Sequence No	PIC X(02)
34	Record ID	PIC X(03)
35	Edit Message Code	PIC X(07)
36	Service From Dt	PIC X(08)
37	Service To Dt	PIC X(08)
38	Input Field	PIC X(15)
39	Computed Field	PIC X(15)
40	Filler	PIC X(20)

The following data item occurs 1 time:

41	Filler	PIC X(70)

Note

This is intended as a reference to be used to interpret The Travelers electronic claim acknowledgment.

EMC Claim Acknowledgment Specifications

This is intended as a reference to be used to interpret The Travelers electronic claim acknowledgment. This reference addresses only Medicare Part B and Commercial claim-specific information.

Field Number:	Positions From:	To:	PIC - Field Length:	Field Name/Description:
01	01	16	X(16)	SUBMITTER ID Submitter ID number contained in the EMC transmission. (NSF AA0-02.0)
02	17	22	X(06)	PROCESS DATE The date the EMC file was processed at The Travelers. Format is YYMMDD, where: YY = Year MM= Month DD = Day
03	23	30	X(08)	PROCESS TIME The time of day that the EMC file was processed at The Travelers. Format is HHMMSSZZ, where: HH= Hours MM = Minutes SS = Seconds ZZ = Hundreds of a second
04	31	36	X(06)	FILLER
05	37	41	X(05)	CARRIER NUMBER The five position carrier ID number from the EMC transmission. (NSF AA0-17.0)
06	42	57	X(16)	SUBMITTER CODE Submitter ID number contained in the EMC transmission. Same as field # 01.0.
07	58	63	X(06)	SUBMISSION NUMBER The unique number assigned by the submitter's system to identify the EMC file. (NSF AA0-05.0)
08	64	71	X(08)	SUBMITTER CREATE DATE The date the file was created by the submitter. (NSF AA0-15.0)
09	72	79	X(08)	SUBMISSION TIME Submitter's time stamp on the EMC file. (NSF AA0-16.0)
10	80	83	X(04)	TEST/PRODUCTION INDICATOR Code used by the submitter to indicate whether the EMC file was for test or production. Values are: TEST or PROD. (NSF AA0-21.0)
11	84	86	X(03)	RECORD SEQUENCE NUMBER Unique sequence number used to identify how many confirmation records are sent as part of this acknowledgment. Begins at 001 and increases by one after each set of 20 edit messages sent back to the submitter.
12	87	88	X(02)	REGION INDICATOR Internal code used by Travelers to identify submitted files.

13	89	89	X(01)	EMC MEDIUM Internal code used to indicate the telecommunications method of transmission for this EMC file. Values are: A - Asynch S - Supertracs N - NDM I - Advantis
14	90	100	X(11)	CHARGES SUBMITTED The total amount of charges received in this EMC file. Format is $$$$$$$$$.cc, implied decimal point.
15	101	109	X(09)	CLAIMS SUBMITTED The total number of claims received in this EMC file. Maximum value is 999999999.
16	110	120	X(11)	CHARGES ACCEPTED The amount of charges from this file that were accepted for processing. Format is $$$$$$$$$.cc, implied decimal point.
17	121	129	X(09)	CLAIMS ACCEPTED The number of claims received in this EMC file that were accepted for processing. Maximum value is 999999999.
18	130	140	X(11)	CHARGES REJECTED The amount of charges from this file that were rejected because of errors. Format is $$$$$$$$$.cc, implied decimal point.
19	141	149	X(09)	CLAIMS REJECTED The number of claims received in this EMC file that were rejected because of errors. Maximum value is 999999999.
20	150	189	X(40)	EMC CONTACT The name of Travelers' EMC unit to be contacted for further information regarding this EMC confirmation.
21	190	199	X(10)	EMC CONTACT PHONE NUMBER The telephone number of Travelers' EMC unit.
22	200	350	X(151)	FILLER

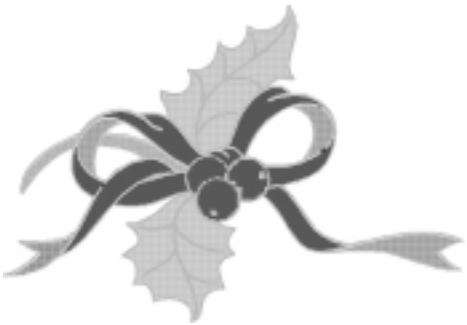
The following data items occur 25 times for each claim which was rejected. They point to specific claims and indicate specific edit messages.

Field Number:	Positions From:	To:	PIC - Field Length:	Field Name/Description:
23	351	362	X(12)	INSURED ID NUMBER The insured's identification number. Can be either the SSN or HICN. (NSF DA0-18.0)
24	363	379	X(17)	PATIENT CONTROL NUMBER The unique patient control number used to identify claims for this patient. (NSF CA0-03.0)
25	380	396	X(17)	FILLER

26	397	411	X15)	EMC PROVIDER ID Code used to identify the provider submitting this claim. Can be either the EMC Biller Code or the Provider Tax ID number. (NSF BA0-02.0)
27	412	415	X(04)	BATCH NUMBER Sequential number assigned by the submitter to each batch of claims. (NSF BA0-04.0)
28	416	421	X(06)	SEQUENCE NUMBER The Travelers internally generated number.
29	422	424	X(03)	LINE NUMBER The Travelers internally generated number.
30	425	426	X(02)	EDIT SEQUENCE NUMBER The Travelers internally generated number.
31	427	429	X(03)	RECORD ID The record identifier that this edit message pertains to.
32	430	436	X(07)	EDIT MESSAGE CODE The code that identifies the edit message pertaining to this record. See EMC CLAIM REJECT ERROR CODES documentation for details.
33	437	444	X(08)	SERVICE FROM DATE The service from date that this edit message pertains to.
34	445	452	X(08)	SERVICE TO DATE The service to date that this edit message pertains to.
35	453	467	X(15)	INPUT FIELD The submitted input field value that this edit message pertains to.
36	468	482	X(15)	COMPUTED FIELD The computed or expected value, if applicable, for the specific input field that this edit message pertains to.
37	483	496	X(14)	FILLER
38	480	494	X(15)	INPUT FIELD The submitted input field value that this edit message pertains to.
39	495	509	X(15)	COMPUTED FIELD The computed or expected value, if applicable, for the specific input field that this edit message pertains to.
40	510	523	X(14)	FILLER

The following data item occurs 1 time per acknowledgment record.

Field Number:	Positions From:	To:	PIC - Field Length:	Field Name / Description:
41	3931	4000	X(70)	FILLER



Parenteral and Enteral Therapy

To insure that claims for parenteral and enteral pumps are processed correctly, bill for the full month with one number of service. For example:

DOS	0601060194
POS	12
Code / Mod.	B9004RRKJ
Charge	$120.00
NOS	1

Action code 311 indicates 15 payments have been processed. Capped rental items must be billed monthly. Due to normal billing practices and DMERC interface with HCFA host systems, PEN pump billing must be done on a monthly basis.

Include the medical necessity documentation to warrant over 35 cal / kg / day requirement. Billing for nutrients requires the exact date span that the nutrients are being billed for. For example:

DOS	0601063094
POS	12
Code	B4150
Charge	$350.00
NOS	305

When submitting the initial claim or the recertification of a claim for the pump, include the additional documentation in question 15 of the DMERC CMN 10.01. Examples of such documentation can include ICD-9 codes or narrative descriptions. Without this information, claims will be denied with action code 221.

Note: The following ICD-9 codes are no longer valid for enteral pump justification: 558.1-558.3, 558.9, 536.0, 536.8, 001.0-008.8, 009.0 -009.3, 787.0, 496, 564.5, and 530.81. In addition, the verbiage utilized for pump justification such as emesis, nausea and vomiting, reflux, regurgitation, slow rate of administration, severe diarrhea or gravity feeding not tolerated will need to include additional documentation to justify medical necessity.

Resubmittals vs. Reviews

Resubmittals

Claims should be resubmitted (refiled) if:

- ❑ The original claim was denied (no payment was issued) due to an error on the part of the supplier, which can be corrected.

  Errors of this type may include, but are not limited to, an incorrect HIC number, date of service, or HCPCS code.

- ❑ The original claim was denied (no payment was issued) due to missing or incomplete information (i.e., lack of a Certificate of Medical Necessity). The claim can be resubmitted with the additional or corrected information.

Reviews

Claims may be reviewed if:

- ❑ The original assigned claim was denied due to a lack of medical necessity.
- ❑ The original assigned claim was denied and the decision is not satisfactory to the supplier.
- ❑ The original assigned claim was partially paid and the supplier is not satisfied with the decision.

Note: When submitting claims for review, indicate exactly what is to be reviewed and why you feel the claim was processed incorrectly.

Note

If the Region A DMERC receives a CMN without a claim or receives a CMN after the claim has been denied, the CMN will be entered into our system. If any assigned claims have been denied prior to the DMERC receiving the CMN, the claims will need to be resubmitted by the supplier.

Wheelchairs

Wheelchair Coding Guidelines

Quickie (Manual)

K0004 RX, EX, Breezy

K0005 GPV, GPS, Quickie 2 & 2HP Shadow, Carbon, TI

Quickie (Electric)

K0011 P100, P200

K0012 P110

K0014 P300

Invacare (Manual)

K0001 Tracer, Tracer Plus, Tracer LX, K0108 for Extra Width or Depth

K0002 Tracer LX-Hemi, K0108 for Extra Width or Depth

K0003 Tracer Light, Action Patriot, K0108 for Extra Width or Depth
Ride-Lite 2000, K0108 for Extra Width or Depth

K0004 Ride-lite 9000, K0108 for Extra Width or Depth

K0005 Action XTRA, Action MVP, Action Style, Action PRO-T, Action Super PRO-T, Action PRO, K0108 For Extra Width or Depth

K0006 Rolls 900 (Weight Limit 250 Lbs), Rolls 4000 (weight Limit 325 Lbs) (16-18 Inch Seat Width), K0108 for Extra Width or Depth

K0007 Rolls 900 (Weight Limit 350 lbs), Rolls 4000 (Weight Limit 425 lbs) (20-22 Inch Seat Width), K0108 for Extra Seat Width or Depth

Invacare (Electric)

K0010 Ranger II, K0108 For Extra Seat Width or Depth

K0011 * Ranger X, Storm Torque, Power Tiger, K0108 for Extra Seat Width or Depth

K0012 Power 9000, K0108 for Extra Seat Width or Depth

K0013

K0014

E & J (Manual)

K0001 Universal, Traveler, Vista

K0002 Universal, SPF2

K0004 P-2 Plus, EZ Lite, Milleneum

K0005 Vision FX, Vision Nitro, Vision Record, Epic

K0006 Universal, 22" Width

K0007 Premier Classic

E & J (Electric)

K0010 Sprint

K0011 X-Caliber, Magnum, Lancer

K0012 Tempest

Permobile (Electric)

K0011 Base

K0014 Recline or Tilt-in-Space

Redman

K0011 Power Road Warrior, Road Savage

K0014 PWER Recline, Geronimo PR

Road Savage-250 Lbs,350 Lbs- K0011 with K0108 for Extra Width or Depth

Additional Documentation

Additional documentation for EMC custom wheelchair claims must ***not*** be fax'd. The additional information must be sent Federal Express to the following:

DMERC Region A
60 E. Main St.
Nanticoke, PA 18634
ATTN: Carol Menichillo
Wheelchair Unit

Crossover

Blue Cross/Blue Shield of Connecticut is now a complementary crossover entity. Please make the following update to your *Supplier Manual*. The OCNA number for BC/BS of Connecticut, 06473B001, is no longer correct. The new OCNA number for this entity is 06473C001.

Empire Blue Cross/Blue Shield recently became a complementary insurer. Exhibit A, below, identifies the status of other complementary entities in production. Exhibit B, on the next page, identifies the crossover status of the Blue Cross Blue Shield organizations.

Exhibit A

Complementary in Production (October 3, 1994)

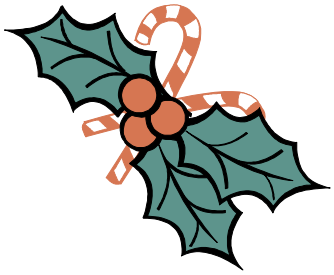
	Par:	Non-Par:	Assigned:	Non-Assigned:
Aetna	X	X	X	X
Mutual of Omaha	X	X	X	X
BC/BS of Rhode Island	X	X	X	X
AARP/ Prudential	X	X	X	X
American General	X	X	X	X
APWU	X	X	X	X
BC/BS Alabama	X	X	X	X
BC/BS Delaware	X	X	X	X
United American	X	X	X	X
The Hartford (ITT)	X	X	X	X
BC/BS Michigan	X	X	X	X
NALC	X	X	X	X
BC/BS of PA	X	X	X	X
BC/BS of Western NY	X	X	X	X
Olympic Health	X	X	X	X
American Republic	X	X	X	X
BC/BS CT	X	X	X	X
Empire BC/BS	X	X	X	X

Exhibit B

Status of BC/BS (October 3, 1994)

	Medigap:	Complementary:	Par:	Non-Par:	Assigned:	Non-Assigned:
BC/BS Michigan		X(E)	X	X	X	X
Empire BC/BS		X(E)	X	X	X	X
BC/BS Rhode Island		X(E)	X	X	X	X
BC/BS Alabama		X(E)	X	X	X	X
BC/BS Delaware		X(E)	X	X	X	X
BC/BS Maine	X(E)		X		X	
BC/BS Massachusetts	X(P)		X	X		
BC/BS National Capital	X(P)		X	X		
BC/BS New Hampshire	X(P)		X	X		
BC/BS Utica (Watertown)	X(P)		X	X		
BC/BS Connecticut		X(E)	X	X	X	X
BC/BS Vermont	X(P)		X		X	
BC/BS Illinois	X(P)		X		X	
BC/BS New York	X(P)		X		X	
BC/BS New Jersey	X(P)		X		X	
BC/BS of PA		X(E)	X	X	X	X
BC/BS of Western NY		X(E)	X	X	X	

Key: P = Paper Output; E = Electronic Output



Miscellaneous

Letter Indicating Upcoming Expiration of Certificate of Medical Necessity

The following letter is sent to suppliers when a certificate of medical necessity is within two months of expiring. This is a system-generated letter that does not differentiate between capped rental items and items which need periodic renewals of CMNs. If you received this letter and feel that it was sent to you in error, or if you have any questions regarding the letter, please contact the Provider Services Unit at (717) 735-9445. A representative will research the dates of the CMN in question to determine if a renewal is required.

Dear Supplier:

The (NAME OF ITEM) is within two months of its medical necessity expiration date (DATE). If subsequent claims for the indicated item are submitted after the expiration date, processing of these claims could be affected. Therefore, where applicable, you should submit a revised certification prior to or in conjunction with, any subsequent claims billed.

Change of Address Reminder

All changes of address must be made through the National Supplier Clearinghouse (NSC). Verbal requests can be made by calling the NSC at (803) 754-3951. Change of address forms are available through the Region A DMERC or the NSC. The completed form must be fax'd or mailed to the NSC at Palmetto Government Benefits Administrators, P.O. Box 100142, Columbia, SC 29202-3142. The completed forms should not be sent to the Region A DMERC.

Oral Anti-Cancer Drugs

When billing for oral anti-cancer drugs, be sure to use the 11 digit NDC number found in the *Drug Topics Red Book*. The number on the manufacturer's package should not be used to identify the drug being billed. Claims will be denied if the manufacturer's number is used in place of the Red Book NDC number. A listing of the oral anti-cancer drugs and their respective NDC numbers can be found on page 4 of the March edition of *DME Medicare News.*

Anti-Fraud Reminder

The following article appeared in a recent Region B newsletter. With their permission, we are reprinting it in our newsletter as we feel it is information that may be of interest to you. Thanks to AdminiStar Federal, the Region B DMERC, for allowing us to reprint this information.

> The Health Care Financing Administration (HCFA) is aware of physicians and suppliers who bill beneficiaries for the 10% penalty payment reduction that is applied to Medicare assigned claims filed more than twelve (12) months after the date of service. On assigned claims the physician / supplier may only charge the beneficiary for any portion of the un-met annual deductible, for the co-insurance, and / or for Medicare non-covered services. Since the 10% late claim filing penalty does not fall within one of these three categories, physicians or suppliers can not bill the beneficiary for the reduction.
>
> Physicians or suppliers engaging in this practice are subject to sanctions, imposing monetary penalties and / or exclusions from the Medicare program.

Supplier Manual Correction

Please make the following correction to page 13-24 of the *Supplier Manual*:

L0504 LSO, lumbar flexion (Williams flexion type)

should be

L0540 LSO, lumbar flexion (Williams flexion type)

Convex Ostomy Supplies

The HCPCS code for a convex insert is A5093. When billing for any other convex ostomy supply, the HCPCS code A4421 (miscellaneous ostomy supply) must be used. A description of the item must be included with the claim when billing for A4421 (i.e. Manufacturer — Hollister Guardian F with Firstchoice convex barrier, Hollister Firstchoice pouch with convex barrier, or any other name brand and description of ostomy supply being billed).

Hints for Completing the HCFA-1500 Form

Medicare must be indicated in Block 1 if the services billed are for Durable Medical Equipment.

- ❑ Block 33 must be completed with the provider's name, address and NSC number. Note that all 10 digits of the NSC number must be reported.
- ❑ Small pharmacy receipts must be placed in the lower section of Block 24 or on a separate piece of paper.
- ❑ Do not put the DMERC address in the upper right-hand corner of the HCFA-1500 Form. This is a vital area needed for internal claim control numbers. If other information appears in this area, the DMERC control number may be difficult to read and this may slow the processing of the claim. Please leave this area blank.

All DMEPOS claims to be processed by the Region A DMERC must be mailed to: DMERC Region A, P. O. Box 6800, Wilkes-Barre, PA 18773-6800. Mailing claims to other Travelers offices or to the Health Care Financing Administration (HCFA) causes delays in the processing of the claims.

Hospice

Be advised that payment for all drugs related to the treatment of a hospice electing beneficiary's terminal or related conditions is included in the payment made to the hospice provider under Part A.

There are two instances whereby the DMERC can be billed and can issue payment for these drugs to a hospice provider:

1. The beneficiary has not elected Medicare Hospice Benefit, or

2. It has been medically determined that the prescribed oral anti-cancer drugs are not related to treating the terminal illness or related condition for which hospice was elected.

All coverage and payment rules apply to the above.

Billing for Ventilators

The correct procedure when billing for 2 (two) ventilators is as follows:

1. Bill the stationary ventilator using the specific item number as a separate line item.

2. Bill the second ventilator as a separate line item using E1399 as the code with a valid description.

This is effective for claims with dates of service October 1, 1993 and after.

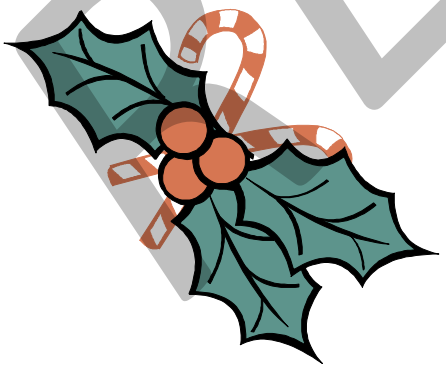
Pricing

XX009	Dobutimine (Dobutrex) 250 mg	$43.94
J3370	Vancomycin HCl 500 mg	$7.80
J2275	Morphine Sulfate Pt. up to 10 mg injection	$9.80
J1170	Hydromorphane (Dilaudid) 4 mg	$1.26
J2270	Morphine Sulfate up to 10 mg injection	$1.06

1995 Holiday Schedule

The following information is the Travelers 1995 fixed holiday schedule. The Region A DMERC will be closed for business on these days. Please retain this schedule so that your business with the DMERC can be conducted before or after these holidays.

❑ New Year's Day	Monday, January 2
❑ Memorial Day	Monday, May 29
❑ Independence Day	Monday, July 3 Tuesday, July 4
❑ Labor Day	Monday, September 4
❑ Thanksgiving	Thursday, November 23 Friday, November 24
❑ Christmas	Monday, December 25



Seasons' Greeting and a Happy New Year

...from the Region A DMERC