DME Medicare News

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

No. 6 TheTravelers March, 1994

New York and Massachusetts Suppliers Change Transition Date to DME Regional Carrier

The transition dates for New York and Massachusetts suppliers have been changed to allow for a smoother overall transition. The transition dates have been extended to April 1, 1994 for New York and May 1, 1994 for Massachusetts.*

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Contacts

DME Region A Service Office
The Travelers Insurance Group . . . . . (717) 820-5700
Supplier Toll-Free Number . . . . . (800) 842-2563
Enrollment Questions:
National Supplier Clearinghouse . . . . . (800) 851-3682
Electronic Media Claims . . . . . (800) 842-1305
FAX . . . . . (717) 820-5850

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:

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

Joanne Policare, Editor (717) 820-5895

Transfer Dates

Because many suppliers may have already made systems and other changes, suppliers billing paper claims or EMC in New York and Massachusetts have the option of billing the Region A DMERC beginning on March 1, as scheduled, or continuing to bill their local New York and Massachusetts carriers until the new transition date, April 1 or May 1 respectively. Suppliers that bill the Region A DMERC beginning March 1 must follow DMERC processing guidelines (i.e., new DMERC certificates of medical necessity must be used when required, new DMERC procedure codes must be used, and claims submitted electronically must be in the National Standard Format). Suppliers that continue to bill the New York and Massachusetts carriers should continue to bill as they have in the past.

RRB Annuitant Claims

Suppliers not billing the Region A DMERC, April or May respectively, will continue to submit RRB claims to The Travelers RRB office. This will prevent situations that require suppliers to submit Medicare DMEPOS claims to New York and Massachusetts carriers, and RRB annuitant claims to the appropriate regional carrier, based on beneficiary residence.

Therapeutic Shoes

Suppliers not billing the Region A DMERC until April or May will continue to submit therapeutic shoes claims to The Travelers Insurance Group, Richmond, VA.

† *Other DMERC transition changes include Texas and Florida. The transition date is April 1 for Texas and May 1 for Florida.*

New Coverage of Oral Anti-Cancer Drugs

Effective January 1, 1994, Medicare Part B coverage is extended to include oral anti-cancer drugs approved by the Food and Drug Administration (FDA). Section 13553(a) of the Omnibus Reconciliation Act of 1993 (OBRA 93) provides for coverage of oral, self-administered, anti-cancer chemotherapeutic agents. The oral form of the anti-cancer agent must contain the same active ingredients used for the same indication as the non-self-administrable form of the drug. Section 13553(b) provides for greater uniformity in determining coverage of off-label uses of FDA approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen for a medically accepted indication.

Coverage Limitations

For Part B coverage, an oral anti-cancer drug must:

- ❑ Be prescribed by a physician or practitioner licensed to prescribe the drug as an anti-cancer chemotherapeutic agent;
- ❑ Be an FDA approved drug or biological;
- ❑ Have the same active ingredients as a non-self-administrable (e.g., injectable) drug or biological that would be covered when furnished incident to a physician's service. To have the same active ingredients, the oral drug and the non-self-administrable drug must have the same chemical/generic name as indicated by the FDA's *Approved Drug Products* (Orange Book), *Physician's Desk Reference* (PDR), or an authoritative drug compendium;
- ❑ Be used for the same indications, including unlabeled uses, as the non self-administrable version of the drug; and
- ❑ Be reasonable and necessary for the individual patient.

OBRA 1993 provides for coverage of off-label (unlabeled) uses of anti-cancer drugs for medically accepted indications. Off-label uses are covered if the use of the anti-cancer drug is supported favorably in the *American Hospital Formulary Service Drug lnformation*, the *American Medical Association Drug Evaluations*, and/or the *United States Pharmacopoeia Drug Information*. If unlabeled uses do not appear in these compendia, unlabeled uses may be considered medically accepted if supported by clinical research in peer reviewed medical literature and journals or determined by the carrier to be generally medically accepted as safe and effective for the particular use.

Prescriptions

A physician or other practitioner (e.g., physician assistant or nurse practitioner) permitted by license to write prescriptions for legend drugs must prepare a written order (i.e., a prescription) or verbal order for an oral anti-cancer drug. The prescription must be filled by a supplier (i.e., pharmacy or dispensing physician or other practitioner) licensed to dispense legend drugs. Verbal orders must be transcribed and maintained in accordance with state pharmacy statutes.

Currently, the following drugs meet the requirements for coverage under OBRA 1993. Use the following NDC numbers to bill for these drugs.

Generic/Chemical Name	How Supplied	National Drug Codes	
Cyclophosphamide	25 mg/ORAL	00015-0504-01	
	50 mg/ORAL	00015-0503-01	
		00015-0503-02	
Etoposide	50 mg/ORAL	00015-3091-45	
Methotrexate	2.5 mg/ORAL	00536-3998-01	00904-1749-60
		00536-3998-36	00378-0014-01
		00005-4507-23	58469-3998-30
		00555-0572-35	00603-4499-21
		00555-0572-02	00364-2499-01
		00781-1076-36	51079-0670-05
		00781-1076-01	51432-0522-03
		00182-1539-01	
Melphalan	2 mg/ORAL	00081-0045-35	

HCFA-1500 Form

In addition to patient and insured information, the following information must be included on the HCFA-1500 form:

- ❑ Item 17 must contain the name of the physician or other practitioner licensed to prescribe the oral cancer drug;
- ❑ Item 17a must contain the unique physician identification number (UPIN) for physicians or the surrogate UPIN "NPP000" for practitioners;
- ❑ Item 21 or item 24E must contain the ICD-9 diagnosis code of the cancer for which the patient is receiving the drug;
- ❑ Item 24D must contain the NDC number for the oral anti-cancer drug;
- ❑ Item 24F must contain the charge;
- ❑ Item 24G must contain the number of units dispensed. Each tablet or capsule equals one unit;
- ❑ Item 33 must contain the supplier name and billing number issued by the NSC;

A separate HCFA-1500 form must be prepared for injectable forms (parenteral route) of anti-cancer drugs and must be submitted to the local carrier.

Please ensure that a valid Health Insurance Claim (HIC) number is submitted in Block 1A of the HCFA-1500 Form. Invalid numbers result in returned claims, delayed payments, and payment to the wrong beneficiary.

HIC numbers can be obtained from the beneficiary's retirement red, white, and blue Medicare card issued by the Railroad Board or Social Security Department. These numbers contain six or nine digits with a suffix or prefix.

Payment

To determine the reasonable charge for oral anti-cancer drugs, the approved payment is based on the lower of the actual charge, the average wholesale prices (AWP) for the generic form of the drug, or, in the case of multiple source drugs, the median of all the AWPs, or an estimate of actual acquisition costs. In determining the median of the AWP for the generic form of the drug, the latest editions of such sources as *Drug Topics Red Book*, *American Druggist Blue Book* or *Medispan* are used. Prices are updated quarterly.

Payment is subject to Part B deductible and coinsurance. Medicare pays 80 percent of the approved drug allowance, subject to the annual Part B deductible.

Where to Submit Claims. — The residence of the beneficiary determines the regional carrier that processes the claim. Submit claims for oral anti-cancer drugs to the appropriate regional carrier. Contact the appropriate regional carrier for advice concerning Medicare coverage of oral anti-cancer drugs.

The Travelers Insurance Group
P.O. Box 6800
(CIGNA)
Wilkes-Barre, PA 18773-6800
(800) 842-2563 *

Connecticut
Delaware
Maine
Massachusetts
New Jersey
New Hampshire
New York
Pennsylvania
Rhode Island
Vermont

AdminaStar Federal, Inc.
P.O. Box 7027 (Assigned)

P.O. Box 7031 (Unassigned)
Indianapolis, IN 46207-7078
(800) 346-2233

District of Columbia
Illinois
Indiana
Maryland
Michigan
Minnesota
Ohio
Virginia
West Virginia
Wisconsin

Palmetto Government
Benefits Administrators

Medicare DMERC Operations
P.O. Box 100141
Columbia, SC 29202-3141
(800) 847-4432

Alabama
Arkansas
Colorado
Florida
Georgia
Kentucky
Louisiana
Mississippi
New Mexico
North Carolina
Oklahoma
Puerto Rico
South Carolina
Tennessee
Texas
Virgin Islands

Connecticut General Life
Insurance Company

P.O. Box 690
Nashville, TN 37202
(800) 488-4184

Alaska
Arizona
California
Guam
Hawaii
Idaho
Iowa
Kansas
Missouri
Montana
Nebraska
Nevada
North Dakota
Northern Mariana Islands
Oregon
South Dakota
Utah
Washington
Wyoming

Oral Anti-Cancer Drug Provision

The Omnibus Budget Reconciliation Act of 1993 includes the coverage of oral anti-cancer drugs provided on and after January 1, 1994. The Regional Carriers will determine the allowance for approved drugs by comparing and selecting the lowest of:

- ❏ Submitted or Actual Charge
- ❏ Average Wholesale Price (AWP)
- ❏ Estimated Acquisition Costs
- ❏ Median of all AWPs in the case of multiple source drugs

In determining the median of the AWP for the generic form of the drug, the latest editions of such sources as *Drug Topics Red Book, American Druggist Blue Book* or *Medispan* are used. Prices are updated quarterly. Payment is subject to Part B deductible and coinsurance. Medicare pays 80 percent of the approved drug allowance, subject to the annual Part B deductible.

The following amounts reflect a *per tablet* basis.

Drug/NDC:	Dosage:	AWP:
Melphalan:		
00081-0045-35	2mg / oral	$1.49
Cyclophosphamide		
00015-0504-01	25mg / oral	$1.45
00015-0503-01	50mg / oral	$2.59 *
00015-0503-02	50mg / oral	$2.59 *
00015-0503-03	50mg / oral	$2.59 *
Etoposide:		
00015-3091-45	50mg / oral	$33.73
Methotrexate:		
00536-3998-01	2.5mg / oral	$2.86 *
00536-3998-36	2.5mg / oral	$2.86 *
00005-4507-23	2.5mg / oral	$2.86 *
00555-0572-35	2.5mg / oral	$2.86 *
00555-0572-02	2.5mg / oral	$2.86 *
00781-1076-36	2.5mg / oral	$2.86 *
00781-1076-01	2.5mg / oral	$2.86 *
00182-1539-01	2.5mg / oral	$2.86 *
00904-1749-60	2.5mg / oral	$2.86 *
00378-0014-01	2.5mg / oral	$2.86 *
58469-3998-30	2.5mg / oral	$2.86 *
00603-4499-21	2.5mg / oral	$2.86 *
00364-2499-01	2.5mg / oral	$2.86 *
51079-0670-05	2.5mg / oral	$2.86 *

** Median AWP used*

Sample Beneficiary Notification Letter

Dear Beneficiary:

Beginning January 1, 1994, Medicare Part B covers certain oral anti-cancer drugs that are prescribed for treating forms of cancer. Up until this time, Medicare only covered cancer drugs administered by injection.

Who May Furnish Anti-Cancer Drugs

Suppliers (other than hospitals) of oral anti-cancer drugs generally include pharmacies, physicians, and outpatient hospital pharmacies who are licensed by State law to dispense prescription drugs. Your pharmacist, physician, or outpatient hospital pharmacy submits the claim on your behalf.

Payment for Oral Anti-Cancer Drugs

Suppliers submit these claims to one of four regional carriers. The supplier may ask you for your permanent residence so it may determine to which of the four carriers your claim should be sent. Payment for the oral anti-cancer drug is subject to the annual Part B deductible and a 20 percent coinsurance. An outpatient hospital pharmacy submits oral anti-cancer drug claims to the hospital's Part A intermediary.

The supplier that participates (or accepts assignment) cannot bill you for more than the difference between the carrier's approved charge and what the carrier pays to the supplier for the item. You are still responsible to the supplier for the Medicare coinsurance and any portion of the Medicare deductible not met.

Coverage Under Your Medigap Insurance Policy

When drugs are covered as regular Part B expenses and Medicare approves a claim, all Medigap policies must pay the coinsurance amount associated with these items.

Inquiries

If you have any questions concerning Medicare coverage of oral anti-cancer drugs, please call or write us.

Supplier Number

The supplier must have a Medicare supplier billing number which is obtained by writing the National Supplier Clearinghouse at P.O. Box 100142, Columbia, SC 29202-3142, or calling the NSC Toll-free number (800) 851-3682. Suppliers without a valid Medicare supplier billing number may not receive Medicare payment for their claims. All suppliers with or without a Medicare supplier billing number must submit claims for oral anti-cancer drugs on the HCFA-1500 Form.

Change of Address

All change of address requests must be made through the NSC. Verbal requests can be made using the NSC Toll-free number (800) 851-3682. The NSC developed a short Change of Address notification form which is used instead of filing a revised HCFA-192 Form.

The NSC Change of Address forms are available through the NSC or the Region A DMERC; but the completed form must be fax'd or mailed to the NSC at Palmetto Government Benefits Administrators, National Supplier Clearinghouse, P.O. Box 100142, Columbia, SC 29202-3142.

Inquiries

If you have any questions concerning Medicare coverage of oral anti-cancer drugs, contact the regional carrier (refer to page 3, "Where to Submit Claims"). The regional carrier will advise you of any changes in requirements.

Beneficiary News

Beneficiary Presentations

Presentations for Medicare beneficiaries are being held throughout the 10-state region. Presentations are scheduled with beneficiary organizations in the following areas:

March 13	Indiana, PA
March 22	Bangor, ME
March 31	Princeton, NJ
May 5	Middletown, CT
May 9	Manchester, NH
May 17	New York, NY

Each presentation lasts approximately one hour. The agenda includes:

- ❑ Introduction
- ❑ Regionalization / DMERC
- ❑ "The Travelers Region A DMERC Beneficiary Program" (18 minute film)
- ❑ Impact on Beneficiaries
- ❑ Physician's Role
- ❑ Supplier's Role
- ❑ Medical Policy Overview
- ❑ Fraud and Abuse
- ❑ Question and Answer Session

If your beneficiary group has 50 or more members and is interested in a DMERC presentation, contact Diane Belles, Professional Relations Nurse Consultant, at (717) 820-5730.

Beneficiary Video

The Region A DMERC has produced a video specifically for beneficiaries. The video explains the changes taking place in Medicare due to the establishment of the DMERCs and how these changes affect the beneficiary. This video will be distributed to beneficiary organizations in this region. In addition, it will soon be telecast on public access television channels throughout Region A.

Crossover

Crossover Types

Mandated Medigap: Eligibility files are not forwarded to The Travelers from the insurer. The output from The Travelers is paper for Participating / Assigned claims only.

Complementary: A contractual arrangement exists between the complementary insurer and The Travelers. The complementary insurer can be a Medigap insurer, supplemental insurer or Medicaid. This insurer must forward eligibility files to The Travelers. The output of claims from The Travelers is electronic. The insurer can choose to receive DME claims that are from Participating / Assigned or Non-participating / Non-assigned Suppliers / Physicians.

Electronic Medigap: A contract is required. Eligibility files are not forwarded to The Travelers from the insurer. The output from The Travelers is electronic for Participating / Assigned claims only.

Medicaid: A contract is required, if the output is electronic. Eligibility files can be sent or The Travelers can key the information from the claim. The output of claims can be paper or electronic for **Participating and Non-Participating/ Assigned claims only.**

Note: The claim output for Medigap is always hard copy. To receive Medigap claim output electronically, a signed contract is required.

Policy Definitions

Medigap: Medigap is a Medicare supplemental insurance. This means that it is designed to cover the gaps in Medicare (coinsurance and deductibles). It meets HCFA standards and is approved and regulated by HCFA. A Medigap policy is offered by a private company to those entitled to Medicare benefits.

Supplemental: A plan or policy offered to employees or former employees, as well as policies offered by a labor organization to members or former members. These plans do not conform to HCFA standards.

HCFA-1500 Form Directions for Medicaid Benefits

The revision of the HCFA-1500 Form in the *Medicare Carrier Manual* (MCM, dated October 1, 1993) indicates the area to be completed regarding Medicare benefits.

Use Block 10d, exclusively, for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by "MCD."

For suppliers and physicians submitting claims, The Travelers Region A DMERC requests that Block 9d, in addition to Block 10d, be completed when the beneficiary is entitled to Medicaid. Block 9d is reserved for the OCNA Number. (OCNA numbers for each Medicaid agency are listed in The Travelers Region A DMERC *DME Medicare News, December 1993 Edition*, and in the Region A *Supplier Manual* on pages 4-21 through 4-42.)

In the *Medicare Carrier Manual* (MCM), completion of Block 9d is not required when the beneficiary is entitled to Medicaid. However, the Region A DMERC requests that Block 9d be completed to ensure crossover.

Crossover Instructions For HCFA-1500 Form Medigap/Supplemental

Medigap

In Block 9 of the HCFA-1500 Form, enter last name, first name and middle initial of the Medigap policy enrollee if it is different from that shown in Block 2. Otherwise, enter the word *SAME*. If no Medigap benefits are assigned, leave the block blank.

In Block 9a, enter the policy and / or group number of the Medigap enrollee, preceded by the word Medigap or the initials MG.

In Block 9b, enter the Medigap enrollee's birth date and sex.

In Block 9c, disregard "the employer's name or school name" which is printed on the form. Enter the claims processing address for the Medigap insurer. Use an abbreviated street address, two-letter state postal code, and zip code copied from the Medigap enrollee's Medigap identification card. For example, 1257 Anywhere Street, Baltimore, Maryland 21204 is shown as "1257 Anywhere St MD 21204."

Note: If a carrier-assigned unique identifier (OCNA number) of a Medigap insurer appears in Block 9d, Block 9c can be left blank.

In Block 9d, enter the name of the Medigap enrollee's insurance company or the Medigap insurer's unique identifier (OCNA number) provided by the local Medicare carrier. If you are a participating supplier / physician, and the beneficiary requests a mandated Medigap transfer, all information in Block 9 and its subdivisions must be complete and correct. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

Note: Only participating suppliers / physicians are to complete Block 9 and its subdivisions, and only when the beneficiary wishes to assign their benefits under a Medigap policy to the participating supplier / physician.

Supplemental

Suppliers / physicians do not list other Supplemental coverage in Block 9 and its subdivisions at the time a Medicare claim is filed. Other Supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file their own supplemental claim.

Complementary Entities

The following list of Complementary Entities have signed contracts with The Travelers Region A DMERC:

- ❑ Aetna
- ❑ Mutual of Omaha
- ❑ Blue Cross and Blue Shield of Rhode Island
- ❑ AARP / Prudential
- ❑ American General
- ❑ APWU
- ❑ Blue Cross and Blue Shield of Alabama
- ❑ Blue Cross and Blue Shield of Delaware
- ❑ United American
- ❑ The Hartford (ITT)
- ❑ Blue Cross and Blue Shield of Michigan
- ❑ NALC

These entities accept DME claims from The Travelers, as a crossover, from both Participating / Assigned and Non-Participating / Non-Assigned suppliers and physicians. An OCNA number is not required when submitting DME claims with one of these entities as secondary insurer. The Travelers will automatically check these entities as part of the adjudication of the claim. The above list will be updated as additions are made.

OCNA Numbers

Below are corrections to the OCNA list published in the December edition of "DME Medicare News":

- ❑ Connecticut Medicaid OCNA # is DIMCT.
- ❑ Massachusetts Medicaid OCNA # is 02110D0001.
- ❑ BCBS of PA should be listed as PA Blue Shield. Use the OCNA #17089B001 when submitting secondary payor claims for BCBS of PA, Blue Shield of PA, or PA Blue Shield.

Note: A revised list, including the above changes, is enclosed with this newsletter as part of the *Supplier Manual* update.

Post-Transition Workshops

The Travelers Region A DMERC is holding Post-Transition Workshops throughout Region A. A workshop schedule, including the dates and locations, is shown on the following page. Two workshops will be held per day.

Morning Session:

Registration	7:30 A.M.
Presentation	8:00 A.M. to 11 :30 A.M.

Afternoon Session:

Registration	12:30 P.M.
Presentation	1 :00 P.M. to 4:30 P.M.

Reservations are required. Complete the form on the bottom of this page. Return the form by FAX or mail to the address shown. For assistance, call our Supplier Toll-Free Number at (800) 842-2563.

The workshops address issues suppliers have encountered in transitioning from local to regional carriers. Each workshop features a discussion on topics such as Electronic Media Claims, Claims Submission (including examples) and Medical Policy, along with a Questions and Answers session. Please bring the following materials to the workshop:

- ❑ DMERC Region A *Supplier Manual*
- ❑ HCFA-1500 Form
- ❑ National Supplier Clearinghouse Number
- ❑ Writing Materials

(Cut here)

Post-Transition Workshop Registration Form

NAME: _____

REPRESENTING: _____

ADDRESS: _____

_____

PHONE NUMBER: _____ NSC NUMBER *(required to attend)* _____

CHECK THE SUPPLIER TYPE: ❑ DME ❑ O&P ❑ OXYGEN ❑ PEN ❑ OTHER

SPECIALTY: _____

WORKSHOP DATE AND LOCATION: _____

SESSION: ❑ A.M. ❑ P.M. NUMBER ATTENDING: _____ *(maximum 4)*

PLEASE COMPLETE THIS FORM AND MAIL OR FAX TO:

MAIL TO: THE TRAVELERS REGION A DMERC
P. O. Box 6800
WILKES-BARRE, PA 18701
ATTN: MARIANNE LOMBARDO

FAX TO: PROFESSIONAL RELATIONS
(717) 820-5750
ATTN: MARIANNE LOMBARDO

Workshop Schedule

The Region A DMERC is holding post-transition workshops throughout Region A. Please note that the workshop scheduled for Schnectady, NY on May 9, 1994 has been canceled; a workshop in Albany, NY is being held in its place.

State	City	Meeting Site		Date of Seminar	Date of Transition
DE	Dover	Sheraton Inn, 1570 North Dupont Highway	(302) 678-8500	03/08/94	01/01/94
NJ	Freehold	Freehold Gardens Hotel, Rt 130 & N/S Freeway	(908) 780-3870	03/14/94	
	Morristown	Governor Morris Hotel, 2 Whippany Road	(201) 539-7300	03/30/94	
PA	Philadelphia	Sheraton Inn Northeast, 9461 Roosevelt Blvd	(215) 671-9600	04/06/94	02/01/94
	Philadelphia	Sheraton Inn Northeast, 9461 Roosevelt Blvd	(215) 671-9600	04/07/94	
	Harrisburg	Marriott Hotel, 4650 Lindle Road	(717) 564-5511	04/08/94	
	Wilkes-Barre	Genetti Best Western, 77 Market Street	(717) 823-6152	04/11/94	
	Monroeville	Radisson Hotel, 101 Mall Blvd	(412) 373-7300	04/14/94	
	Monroeville	Radisson Hotel, 101 Mall Blvd	(412) 373-7300	04/13/94	
NY	Jamaica	Holiday Inn, 144-02 135 Avenue	(718) 659-0200	05/02/94	03/01/94
	Jamaica	Holiday Inn, 144-02 135 Avenue	(718) 659-0200	05/03/94	
	Albany	Omni Hotel, State and Lodge Street	(518) 462-6611	05/09/94	
	Syracuse	Quality Inn North,1308 Buckley Road	(315) 451-1212	05/11/94	
	Buffalo	Raddison Hotel,4243 Genesee Street	(716) 634-2300	05/16/94	
	Elmira	Holiday Inn (Downtown Elmira), East Water Street	(607) 734-4211	05/18/94	
MA	Boston	Tremont House Hotel, 275 Tremont Street	(617) 426-1400	06/01/94	
	Springfield	Sheraton Hotel, 1 Monach Road	(413) 781-1010	06/03/94	

Additional Post-Transition Workshops

The Pennsylvania Association of Medical Suppliers (PAMS) is offering a post-transition educational session featuring Pennsylvania Blue Shield and Travelers representatives. The sessions will be held Tuesday, April 19, 1994, in Pittsburgh, and Wednesday, April 20, 1994, in King of Prussia. For information on the locations and itinerary, please contact the PAMS office.

PAMS represents over 250 home medical equipment and services companies in Pennsylvania and Delaware. For more information on the organization and upcoming educational sessions, telephone the PAMS office at (717) 238-8020.

Orthotics & Prosthetics Workshops

The Professional Relations unit is currently developing a workshop focused specifically on Orthotics and Prosthetics. The workshops are tentatively scheduled to take place in April and May. A schedule and other details will be forthcoming.

Pricing

Frequent HCPCS Code Inquiries

The Statistical Analysis DME Regional Carrier (SADMERC) HCPCS Help Line provides assistance in determining the appropriate HCPCS code to use for particular DMEPOS items. The following is a list of frequent HCPCS code inquiries to the SADMERC. The SADMERC — Palmetto Government Benefits Administrators in South Carolina — can be reached at (803) 736-6809, from 9 a.m. to 12 p.m. and 1 P.M. to 4 P.M. Eastern Standard Time.

E0165	Extra Wide Commode
E0199	Dry Foam Mattress, less than 5" peak height
E0184	Dry Foam Mattress, greater than 5"
A9300	Stimulation Ball Theraputty Therabands Exercise Pulley
E1399	Wheel Attachments to Folding Walkers, Skid and Slides (not Brakes)
K0163	Vacuum Erection System
K0108	22", 34", 36" Wheelchair (Seat only)
L8500	Artificial Larynx
A4572	Rib Binder
L0220	Custom Rib Binder
L3030	Removable Molded Shoe Insert
XX049, Level III	Pulmocare
L3914	Carpel Tunnel Brace
A4554	Diapers, Underpads

New Level II HCPCS Codes - Nebulizer Drugs

J7627	Bitolterol, 0.2%, per 10 ml
J7670	Metaproterenol, 0.4%, per 2.5 ml
J7672	Metaproterenol, 0.6%, per 2.5 ml

1994 Fee Schedule Update

Reimbursement Amounts

The reimbursement amounts for the following codes have been changed or added:

- ❑ Code XX037, Immunaid, per 100 calories, has been adjusted from $2.46 to $2.96.
- ❑ Code J9280, Mitomycin, per 5 mg, has been adjusted to $123.99.
- ❑ Code J9190, Fluorouracil, per 500 mg, has been adjusted from $1.54 to $1.99.
- ❑ Code J9010, Doxorubicin, $225.40 per 50 mg.
- ❑ Code J9200, Floxuridine, $87.50 per 500 mg.

Note: Codes J7051 and XX001 will be priced per milliliter. Price per milliliter will be $0.03.

Test Strips

The fee schedule for HCPCS code A4253 has been revised. The fee schedule base year data for the code was corrupted by data pertaining to urine test strips, per 100. Formerly, both urine test strips and blood glucose test strips were represented by HCPCS code A4253. Urine test strips are now represented by HCPCS code A4250.

The revised fee schedule for code A4253 was calculated using the 1993 maximum allowed payment amounts reported by the local carriers and updated by 3 percent. The revised amounts are effective for all claims with dates of service on or after January 1, 1994. For previously processed claims, providers must request reprocessing through normal carrier procedures and submit requests in the usual manner.

1994 DME Fee Schedule for Code A4253 - Supplies (Purchase New)

CT	$35.31	ME	$30.01
MA	$30.01	NH	$30.01
RI	$35.02	VT	$30.01
NY	$35.31	NJ	$35.31
PA	$35.31	DE	$35.01

Reclassification of K Codes

Effective January 1,1994, K0005 (Ultra Lightweight Wheelchair) and K0009 (Other Manual Wheelchair/ Base) were reclassified from Capped Rental items to Inexpensive or Routinely Purchased items.

The following list identifies the fees for code K0005 for Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New York, New Jersey, Pennsylvania, and Delaware:

Code K0005:	New:	$1,624.78
	Used:	$1,218.58
	Rental:	$162.47

Inexpensive Or Routinely Purchased

The accessory items listed below have been classified as inexpensive or routinley purchased. For accurate processing of claims to occur, modifiers (i.e., NU) must be used with these items.

1994 Fee Schedule

DME Nebulizer Accessories

CODE	ME	NH	VT	MA	RI	CT	NY	PA	NJ	DE
K0168	$2.41	$2.40	$2.41	$2.41	$2.40	$2.41	$2.40	$2.40	$2.40	$2.40
K0169	$1.40	$1.34	$1.35	$1.37	$1.34	$1.37	$1.34	$1.34	$1.34	$1.34
K0170	$26.14	$24.43	$25.40	$25.66	$24.43	$25.76	$24.43	$24.43	$24.43	$24.43
K0171	$7.65	$7.15	$7.45	$7.51	$7.15	$7.53	$7.15	$7.15	$7.15	$7.15
K0172	$3.74	$3.49	$3.64	$3.67	$3.49	$3.68	$3.49	$3.49	$3.49	$3.49
K0173	$9.66	$9.66	$9.66	$9.66	$9.66	$9.66	$9.66	$9.66	$9.66	$9.66
K0174	$35.66	$33.32	$34.65	$34.98	$33.32	$35.12	$33.32	$33.32	$33.32	$33.32
K0175	$20.73	$20.49	$20.73	$20.73	$20.49	$20.73	$20.49	$20.49	$20.49	$20.49
K0176	ICC	ICC	ICC	ICC	ICC	ICC	ICC	ICC	ICC	ICC
K0177	$3.33	$3.14	$3.28	$3.31	$3.14	$3.32	$3.14	$3.14	$3.14	$3.14
K0178	$0.69	$0.65	$0.67	$0.68	$0.65	$0.68	$0.65	$0.65	$0.65	$0.65
K0179	$3.80	$3.55	$3.69	$3.73	$3.55	$3.75	$3.55	$3.55	$3.55	$3.55
K0180	$1.56	$1.45	$1.50	$1.51	$1.45	$1.52	$1.45	$1.45	$1.45	$1.45
K0181	$6.14	$5.73	$5.95	$6.02	$5.73	$6.05	$5.73	$5.73	$5.73	$5.73
K0182	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34	$0.34

CPAP Device Accessories

Previously established CPAP Device Codes are inactive codes. For billing purposes, continue to use the existing Level II E-codes and the E1399 to bill for the humidifier. New codes are being established at this time for these items.

CODE	ME	NH	VT	MA	RI	CT	NY	PA	NJ	DE
K0183	$68.20	$63.73	$66.30	$66.92	$63.73	$67.18	$63.73	$63.73	$63.73	$63.73
K0184	$20.92	$19.55	$20.32	$20.52	$19.55	$20.60	$19.55	$19.55	$19.55	$19.55
K0185	$33.28	$31.12	$32.34	$32.66	$31.12	$32.78	$31.12	$31.12	$31.12	$31.12
K0186	$16.00	$16.00	$16.00	$16.00	$16.00	$16.00	$16.00	$16.00	$16.00	$16.00
K0187	$36.04	$34.46	$35.83	$36.04	$34.46	$36.04	$34.46	$34.46	$34.46	$34.46
K0188	$4.02	$4.02	$4.02	$4.02	$4.02	$4.02	$4.02	$4.02	$4.02	$4.02
K0189	$13.47	$13.47	$13.47	$13.47	$13.47	$13.47	$13.47	$13.47	$13.47	$13.47

Suction Pump Accessories

CODE	ME	NH	VT	MA	RI	CT	NY	PA	NJ	DE
K0190	$7.82	$7.32	$7.61	$7.68	$7.32	$7.71	$7.32	$7.32	$7.32	$7.32
K0191	$28.05	$26.21	$27.26	$27.51	$26.21	$27.63	$26.21	$26.21	$26.21	$26.21
K0192	$3.27	$3.04	$3.16	$3.19	$3.04	$3.20	$3.04	$3.04	$3.04	$3.04

Refer to the December edition of "*DME Medicare News*" for a description of the above K codes.

K Modifiers

Codes that require a K modifier must be submitted with the appropriate modifier:

KH For the first month's rental

KI For the second and third month's rental

KJ For the fourth through the fifteenth month's rental

Do not use any local carrier modifiers (i.e., Z6 or Z7). Refer to the *Supplier Manual*, pages 5-4 through 5-6, for additional information.

Dynasplints

The Level III codes for dynasplints have been reclassified from the Purchase category to the Capped Rental (YY001-YY004, and YY006) and Inexpensive or Routinely Purchased (YY005) categories.

Claim data indicates that these items, except for YY005, are rented more frequently than purchased. The 1994 fee schedule for these items is listed below:

1994 Fees For Dynamic Orthotics Codes

Capped Rental (Rental)

Code	ME	NH	VT	MA	RI	CT	NY	PA	NJ	DE
YY001	$142.23	$132.92	$138.24	$139.57	$132.92	$140.10	$132.92	$132.92	$132.92	$132.92
YY002	$142.23	$132.92	$138.24	$139.57	$132.92	$140.10	$132.92	$132.92	$132.92	$132.92
YY003	$142.23	$132.92	$138.24	$139.57	$132.92	$140.10	$132.92	$132.92	$132.92	$132.92
YY004	$142.23	$132.92	$138.24	$139.57	$132.92	$140.10	$132.92	$132.92	$132.92	$132.92
YY006	$142.23	$132.92	$138.24	$139.57	$132.92	$140.10	$132.92	$132.92	$132.92	$132.92

Inexpensive or Routinely Purchased (Purchase)

Code	ME	NH	VT	MA	RI	CT	NY	PA	NJ	DE
YY005	$70.66	$66.05	$68.70	$69.35	$66.05	$69.62	$66.05	$66.05	$66.05	$66.05

Inexpensive or Routinely Purchased (Rental)

Code	ME	NH	VT	MA	RI	CT	NY	PA	NJ	DE
YY005	$7.07	$6.61	$6.87	$6.94	$6.61	$6.96	$6.61	$6.61	$6.61	$6.61

Inexpensive or Routinely Purchased (Purchase Used)

Code	ME	NH	VT	MA	RI	CT	NY	PA	NJ	DE
YY005	$53.00	$49.54	$51.53	$52.01	$49.54	$52.22	$49.54	$49.54	$49.54	$49.54

Electronic Media Claims

Accelerate Update

The Region A DMERC recently issued The Travelers Accelerate software program to all suppliers requesting the software. Suppliers who did not receive a requested copy should contact the EMC Help-Desk at (800) 842-1305. The Help-Desk is available for installation assistance or to answer any questions.

The EMC Support Team provides assistance over the phone, in addition to walking suppliers through the program. Please contact the EMC Support Team to schedule an appointment with one of our specialists.

EMC Help-Desk

The Travelers EMC Support Team can be reach daily between the hours of 8:00 a.m. and 4:15 p.m. If an answering machine is reached, please leave a message. A Support Team specialist will return the call on the next business day.

EMC Help-Desk
(800) 842-1305

Bulletin Board System

The EMC Bulletin Board System is available to all EMC submitters. This system allows EMC submitters to:

- ❑ Send claims electronically
- ❑ View news bulletins
- ❑ Send messages to the EMC Team
- ❑ Access the electronic weekly status report which shows a history of claims pending, paid and denied.

How to Access the Bulletin Board

Participating and non-participating suppliers can access the Bulletin Board by calling:

Participating Suppliers	(800) 842-5713
Non-participating Suppliers	(717) 820-5892

An electronic submitter number and password are needed to submit claims electronically. To obtain a number and password, call (800) 842-1305.

File Reject vs. Claim Reject

The Region A DMERC EMC Unit is rejecting individual claims instead of entire files. With the inception of claim-level rejects in the EMC process, reporting of error conditions will be different from the previous process. Error reporting will be incorporated in the EMC file acknowledgment letter. A record listing will be added to the letter and will contain error codes that identify the record, field, and error condition. Additionally, the supplier will receive an error code manual which fully describes the error.

The EMC Help-Desk is available to answer any questions. However, to avoid rejected claims, remember to fill in all fields that are required according to the National Standard Format.

Testing For Suppliers

Suppliers using an approved vendor need to test with The Travelers before submitting production claims. To test, please call the EMC Help-Desk to request a Submitter Number and an EMC Agreement.

The following information outlines the testing procedures for suppliers with approved vendors:

1. Once the updated software is received from the vendor, key in a variety of 20-30 claims. Some of these claims must contain CMNs. They can be claims in which payment already has been received.

   - or -

   Use the prepared test packages which are based on the ten Certificates of Medical Necessity, in addition to the Oxygen Certification.

2. Transmit that file to the Region A DMERC. The file will be reviewed and notification of results will be issued within three working days.

Miscellaneous Notes

Newsletter Correction

In the December edition of *DME Medicare News*, the "Physician Completion of CMN" (page 31) article listed paraffin bath in error. Please note that the Region A DMERC does not have a CMN for a paraffin bath, as indicated in this section.

In the February edition of *DME Medicare News*, "Pumps for Enteral Nutrition" (page 4), codes 636.8 and 654.2 were stated in error. The correct codes are 536.8 and 564.2, respectively.

If the listed diagnoses are not used, documentation must be submitted to support the use of the pump.

Hospice Care

Although hospice care is a Part A Medicare benefit, there are certain instances when a DMERC can be billed for medically necessary Part B services rendered to a hospice patient. Because of this, the following information on hospice care is included in this newsletter to better acquaint Region A physicians and suppliers with the hospice benefit.

Hospice is defined as the interdisciplinary approach to care of the terminally ill which provides palliative care and supportive services. Hospice care addresses the spiritual, physical and social needs of the patient and family members. The interdisciplinary team members include but are not limited to physician(s), nurses, nurses aides, social workers, therapists, clergy, and DME providers.

A hospice benefit is available under the Medicare program for beneficiaries who have a terminal illness and are certified by a physician to have a life expectancy of 6 months or less. A beneficiary who chooses to utilize the hospice benefit waives the standard Medicare coverage. Reimbursement for hospice service is only available to Medicare-certified hospices. The duration of the benefit is defined as two 90-day periods, one 30-day period, and a fourth period of unlimited days. Payment will continue to be available under Part B for services provided by the patient's attending physician and services which are not related to the terminal condition. Via a HCFA-1500 Form, the beneficiary may continue to use their private physician, in addition to the hospice physician, while under hospice care.

Under the hospice benefit, the hospice bills the intermediary for all services related to the terminal illness. These services include, but are not limited to: physician services, DME and supplies, prescriptions, nursing services, and social service visits. The hospice must be a Medicare-certified hospice in order for billing and reimbursement to occur. The care and services provided must be palliative and not curative under this benefit. A notice of admission form is filed by the hospice to the intermediary and Part B carrier. A system flag also alerts the DMERC that the beneficiary is under the hospice benefit; therefore, claims for services not related to the terminal illness can be processed and reimbursed accordingly.

If a private physician continues to render services to a patient in the hospice program, the statement, "*Hospice Patient. Dr. _____ is the attending physician and is not employed by the hospice*" must be entered on the HCFA-1500 Form. This statement is recommended to ensure proper billing procedure.

Telecommunication Device For The Hearing Impaired

A Telecommunication Device for the Deaf (TDD) has been installed and can be easily accessed by any supplier or beneficiary who possesses a similar/compatible device. This telephone line is accessible to those who are hearing impaired and need assistance with their Medicare questions. The TDD telephone number is (800) 842-9519. This line is available 24 hours per day, using the following procedure:

- ❑ A supplier or beneficiary may call any time and leave a message.
- ❑ A customer service representative will respond to these calls between 8 A.M. and 4 P.M. (EST), Monday through Friday.

ESRD

For the Region A DMERC to process End Stage Renal Disease (ESRD) claims, the dialysis facility must first submit a completed HCFA-382 Form to their Part A intermediary. ESRD claims, submitted to the DMERC without prior submission of the HCFA-382 Form to the intermediary, will be denied with action code 220 due to lack of information.

The Part A intermediary is responsible for the input and update of ESRD information into the Common Working File (CWF). Direct questions regarding ESRD updates to the Part A intermediary.

Oxygen CERT Records

Processing of electronic Oxygen CERT records in the National Standard Format (GX0) and recent phone inquires indicate that some submitters are improperly completing the fields for test results and flow rate.

The cobol picture for the test results for ABG and oxygen saturation (GX0 fields 18 and 19) is 9(2)v9. This means that these fields must be completed with an implied decimal between positions 2 and 3.

The cobol picture for flow rate (GX0 fields 14 and 24) is also 9(2)v9. Incorrect completion of these fields can result in significant payment problems. The fields must be completed and read with an implied decimal.

For example:

008 = .8

080 = 8.0

800 = 80.0

Please have your programming staff or vendor verify that your claims are being properly completed for these values.

Supplier Number

To ensure proper processing of claims and payment to the correct supplier, the supplier's National Supplier Clearinghouse (NSC) Number must be present in either Block 32 or Block 33 of the HCFA-1500 Form. Do not use old provider numbers. The DMERC will return claims that are submitted without a 10-digit NSC number on the claim.

Orders For Repairs

The DMERC Region A no longer requires an order for repairs on DMEPOS items. However, for wheelchair repairs, document on the claim whether or not the wheelchair is patient owned. A UPIN number is required.

Reminder

When using a miscellaneous procedure code on claims submitted to the DMERC, a description of the item is needed.

Medical Policy

CYTOGAM Used in IV Infusion Pumps

Cytomegalovirus Immune Globulin (Human) (CYTOGAM), used in immunosuppressed patients for Cytomegalovirus (CMV) infection, must be administered by controlled infusion and will, therefore, be covered when administered through an external IV Infusion Pump. When billing for this code, use the HCPCS code J7799. Be sure to include a narrative of the drug's name and amount administered.

CMNs For Air Fluidized Beds

Because air fluidized beds must be recertified every month, the supplier should remind the physician of the medical policy that states that the estimated length of need may not exceed one month.

ICD-9-Dx Codes

If a medical policy cites a specific ICD-9-Dx Code, which indicates the medical necessity of an item, suppliers must ensure that the code is entered on the HCFA-1500 Form, either electronically or hard copy. This will facilitate processing and adjudication of the claim.

Important
Supplier Manual Revisions Enclosed