Special Edition

DME Medicare News

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

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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 Help Line Number . . . . . (717) 735-9445

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Initiative Encourages Mammography Screening

The Health Care Financing Administration (HCFA) is conducting a consumer information initiative to encourage screening mammograms for female Medicare beneficiaries. Although Medicare covers mammograms for the detection of breast cancer, Medicare claims data reveal that less than 40% of older women take advantage of this benefit.

Breast cancer is most common among women over age 65. In 1994, approximately 50 percent of a11 new breast cancer cases were in women age 65 and older; and about 56 percent of the deaths from breast cancer were in women age 65 and older. HCFA encourages and recommends screening mammograms to aid in early detection of breast cancer. In many cases, breast cancer, if detected early, can be treated. Mammograms help save lives.

Medicare covers the performance and interpretation of screening mammograms every one to two years depending on the beneficiary's age and risk factors. Physicians can help to raise beneficiary awareness by discussing with their patients the medical benefits of screening mammograms. As part of the mammography campaign, HCFA has developed informational materials regarding the benefits of mammograms, as well as Medicare coverage issues. This information is available to you.

For 1995, the approved payment amount for the screening mammogram's technical and professional components combined (CPT code 76092) is $60.88. If billed separately, the 1995 payment limit is $41.40 for the technical component and $19.48 for the professional interpretation. Nonparticipating physicians' 5 percent fee schedule reduction does not apply for screening mammograms. Medicare pays 80% of the lowest of the following charges:

- ❑ The physician's actual charge,
- ❑ The amount calculated in the Medicare fee schedule for a diagnostic mammogram, or
- ❑ A fee limit (80% of the $60.88 approved amount which equals $48.70).

For assigned claims, beneficiaries are responsible for any portion of the unmet deductible and the 20% coinsurance. In cases of unassigned claims, beneficiaries are responsible for any portion of the unmet deductible, the 20% coinsurance, and any additional charges up to the limiting charge.

Medicare also covers diagnostic mammograms. Unlike the time interval requirement for screening mammograms, diagnostic mammograms are covered when there is any sign or symptom of breast disease and the woman's doctor orders the exam.

As required by the Mammography Quality Standards Act (MQSA), all facilities performing screening and diagnostic mammograms must be certified by the U.S. Food and Drug Administration (FDA) to qualify for Medicare payment and must display their certification.

As mentioned above, we can provide you with materials for your use and for the use of your patients. Please contact us on (insert phone number or address if appropriate). The materials available include: Medicare claims data showing 1992-1993 mammography utilization rates by state and by race; a HCFA brochure, in English and Spanish, telling older Americans about the benefits of Medicare-covered mammograms; posters supporting the mammography campaign; fact sheets on HCFA's Consumer Information Strategy and the Medicare mammography benefit; and a woman's guide on quality mammograms from the Agency for Health Care Policy and Research.

Miscellaneous

Medicare HMOs

There has been some confusion regarding beneficiaries covered by a Health Management Organization (HMO).

The Health Care Financing Administration contracts with certain HMOs to provide Medicare benefits through a certain network of providers. There are several different types of Medicare HMOs - Risk, Cost and Health Care Prepayment Plan (HCPP). However, the most confusion involves the Risk plan, which is the plan that will have the most impact on your business as a supplier. The following is a brief explanation of the Risk HMO program:

Medicare beneficiaries enrolling in a Medicare HMO must meet the following requirements:

1. Continue payment of their Medicare Part B premiums
2. Live in the HMO services network
3. Cannot have End Stage Renal Disease or have elected hospice coverage upon enrollment

Medicare HMOs do not replace Medicare benefits. A Medicare beneficiary electing a Medicare HMO still has Medicare; the beneficiary is just receiving benefits through an alternative delivery system. Enrollment in a Medicare HMO is voluntary, and there is no need for a Medicare supplemental plan when a Medicare HMO is elected. ***The HMO is not a supplemental plan nor is Medicare a secondary payor to the HMO.***

Medicare HMO members **must** go to an **authorized** HMO **provider** for coverage of supplies under the HMO plan, with the exception of an emergency or urgently needed care situation. **Any other care by a non-plan provider will not be covered by Medicare or by the HMO Plan.** Always check with the beneficiary for Medicare HMO coverage before providing any supplies.

Providers cannot bill Medicare for a beneficiary enrolled as a member with a Medicare HMO. Claims will be denied with action code 600, remarks code H, stating "your claim was transferred to HMO for processing." **Claims denied for this reason should not be resubmitted.**

Delivery Logs

As stated on page 6 of the March 1995 edition of *DME Medicare News* No. 17, a UPS delivery log is an **example** of the type of log that can be used as an acceptable form of proof of delivery for a DMEPOS item.

It is the discretion of the supplier as to the service utilized for delivery of a DMEPOS item. For audit pur-

poses, the Region A DMERC is stating the log or copy must be maintained in the beneficiary's file as would any other documentation.

Immunosuppressive Drugs

The following procedure codes are not valid for DMERC processing from 1993 to present:

J7500 through J7506

When submitting bills, be sure to use the correct K code and correct number of units.

Invalid Procedure Codes:	Valid Procedure Codes:
J7502 Cyclosporine (100mg/ml per 50ml oral solution)	K0121 Cyclosporine (25mg tablets)
J7500 Azathioprine (50mg)	K0119 Azathioprine (50mg)
J7506 Prednisone (100 tablets)	K0125 Prednisone (5mg)

If J7500 through J7506 are billed after the 45-day notification period, all claims will be **denied for incorrect procedure codes**.

The correct code for Prograf in 1994 is XX010 (this is a miscellaneous code); it must be billed with a word description of Prograf, milligrams, and correct number of units.

The correct code for Prograf in 1995 is J7507 (1 milligrams) and J7508 (5 milligrams).

The correct X code or J code for Prograf must be billed for the correct year or they will be denied as incorrect procedure codes.

Additional Documentation for Wheelchairs

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 Street
Nanticoke, PA 18634
Attn: Sandi Evans
Wheelchair Unit

Indicate in the HA0 record that the documentation has been sent.

The information should be sent to Sandi Evans, not Carol Menichillo.

Annoucements

The Region A DMERC announces the following appointments:

- Cathy Wolfgang, R.N.
  HCPCS Coordinator
  (717) 735-9514
- Dave Fiorini
  Congressional Representative
  (717) 735-9404

Medicare Remittance Notice Explanation

Explanation and sample