DMERC

Medicare

News

DMERC Region A Service Office • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800 • Phone (717) 735-9445

Processing System Change Approaching

The Region A DMERC is in the midst of preparation for a major processing system change. **Effective July 1, 1998**, we will begin use of the **Viable Information Processing System (VIPS).**

A total revamping of an entire processing system is a formidable task. DMERC personnel in every unit will be involved in training and related activities between now and the transition date. We are taking steps to lessen the adverse effect on the supplier and beneficiary communities. We ask for your patience and understanding during this time of change.

Fall 1998 Workshops

How can I file an appeal? Do I have the right documentation to send in with my wheelchair claim? Can I still submit the old 484 form? I wonder if I can submit my CMNs electronically? If you ask yourself these or other related questions, register now for our Fall 1998 Workshops.

Agenda

8:30 AM Registration

9:00 AM - 12:00 PM

- Workshop 1 - Electronic Data Interchange
- Workshop 2 - Rehab Specialties/Wheelchair Documentation
- Workshop 3 - Respiratory
- Workshop 4 - Documentation/The Appeals Process

12:00 PM - 1:00 PM Lunch (Provided)

1:00 PM - 4:00 PM

- Workshop 1 - Electronic Data Interchange
- Workshop 2 - Rehab Specialties/Wheelchair Documentation
- Workshop 3 - Respiratory
- Workshop 4 - Documentation/The Appeals Process

Please note: Workshops run concurrently. You must choose one AM session and one PM Session.

Workshops & Locations

October 1	Radisson Eastland Hotel 157 High St. Portland, ME 04101	207-775-5411
October 5	Holiday Inn Downtown 50 Morgan St. Hartford, CT 06120	860-549-2400
October 9	Radisson Hotel Milford 11 Beaver St. Milford, MA 01757	508-478-7010
October 13	Wayfarer Inn 121 South River Road Bedford, NH 03110	603-622-3766
October 15	Sheraton LaGuardia East 135-20 39th St. Flushing, NY 11354	718-460-6666
October 19	Ramada Inn 38 Two Bridges Rd. Fairfield, NJ 07004	973-575-1742
October 21	Radisson Hotel & Suites 4243 Genesee St. Buffalo, NY 14225	716-634-2300
October 23	Sheraton Station Square Sheraton Square Dr. Pittsburgh, PA 15219	412-261-2000
October 26	Ramada Inn Airport 76 Industrial Hwy. Philadelphia, PA 19029	610-521-9600
October 28	Ramada Inn Albany Downtown 300 Broadway Albany, NY 12207	518-434-4111
October 30	Ramada Plaza Hotel 20 Public Square Wilkes-Barre, PA 18701	717-824-7100

All attendees must be pre-registered. Due to limited space, registration is on a first come, first served basis. If a particular workshop is filled to capacity, you will be notified by telephone and given the opportunity to make another selection.

Registrations must be postmarked by September 1, 1998 for all seminar locations. Any registrations postmarked after that date will be returned to the supplier.

If you do not receive a confirmation within 5 days of the workshop for which you have registered, please call our Professional Relations Unit at 717-735-9406.

How To Register

Complete the following registration form and make checks payable to United HealthCare. Return completed form to United HealthCare, Region A DMERC, using the appropriate address as noted on the following page. The registration fee of **$75.00** per person is **non-refundable.**

Once a registration is complete, no changes will be made. Please make your specialty workshop selection very carefully.

Parking information: We do our best to choose locations with ample, cost free parking. Unfortunately, cost free parking is not always available. Please phone the meeting facility for specific information regarding location and parking fees.

In This Issue

Please complete and mail this registration form to:

United HealthCare
Attn.: Seminar Registration
PO Box 6800
Wilkes-Barre, PA 18773-6800

Registration Form

Please complete a registration form for **each** person attending.

Company _____

Provider Number_____Submitter Number (Billing Services Only) _____

Address _____

_____

Phone_____Fax_____

Location of Workshop _____

Amount Enclosed_____

Name of Attendee _____

Contact Name _____

Please check the appropriate box(es) to indicate which workshops you wish to attend.
For example, EDI AM and Respiratory PM.

AM Session (9:00 AM - 12:00 PM)

- ❑ Workshop 1 - Electronic Data Interchange (EDI)
- ❑ Workshop 2 - Rehab Specialties/Wheelchair Documentation
- ❑ Workshop 3 - Respiratory
- ❑ Workshop 4 - Documentation/The Appeals Process

PM Session (1:00 PM - 4:00 PM)

- ❑ Workshop 1 - Electronic Data Interchange (EDI)
- ❑ Workshop 2 - Rehab Specialties/Wheelchair Documentation
- ❑ Workshop 3 - Respiratory
- ❑ Workshop 4 - Documentation/The Appeals Process

The registration fee of **$75.00** per person is **non-refundable.**

Revised CMNs for Capped Rental Items

If a patient requires a capped rental item for less than 15 months, the number of months ordered should be listed on the initial CMN. If subsequent to the initial CMN the doctor orders additional months of need for the patient, the supplier must obtain and submit a revised CMN to the DMERC. This revised CMN must indicate a revised length of need which includes the number of months originally notated on the initial CMN.

For example, the initial CMN documents the length of need as 3 months. After 3 months have passed the physician orders the item for an additional 6 months. The revised CMN must indicate the length of need as 9 months.

Parenteral and enteral nutrition and oxygen are not capped rental items. Please refer to recertification schedules in your *Supplier Manual* and newsletters for instructions on these items.

Millennium Update: Changes to the HCFA-1500 Instructions

As of October 1, 1998, you will be required to enter 8-digit birth dates on Form HCFA-1500 for Medicare, Part B claims. This includes entering 2-digit months (MM) and days (DD), and 4-digit years (CCYY). The reporting requirement for 8-digit birth dates **will not require a revision to the HCFA-1500 claim form**. However, the instructions and printing specifications for the HCFA-1500 claim form were changed so 8-digit birth dates can be reported.

HCFA-1500 Fields Affected by New Reporting Requirement:

Item 3 Patient's Birth Date

Item 9b Other Insured's Date of Birth

Item 11a Insured's Date of Birth

Please note that 8-digit birth dates must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the HCFA-1500 claim form, the space between month, day, and year is delineated by a dotted, vertical line.

To illustrate, if the patient's birthdate is January 21, 1935, then you would enter the following in item 3 of Form HCFA-1500:

3. Patient's Birth Date		
MM 01	DD 21	YY 1935

If you do not submit 8-digit birth dates as of October 1, 1998, your claim will be returned to you as unprocessable.

HCFA-1500 Fields *Not* Affected by New Reporting Requirement:

Item 11b Employer's Name or School Name

Item 12 Patient or Authorized Person's Signature Date

Item 14 Date of Current Illness, Injury, or Pregnancy

Item 16 Dates Patient Unable to Work in Current Occupation

Item 18 Hospitalization Dates Related to Current Illness

Item 19 Reserved for Local Use

Item 24a Date(s) of Service

Item 31 Signature of Physician/Supplier

Note: Item 15 is not required for Medicare, Part B services.

You may enter either a 6 or 8-digit date for these fields (items 11b, 12, 14, 16, 18, 19, 24a, or 31) as of October 1, 1998.

If you choose to enter 8-digit dates for these fields, please note the following:

- **Form HCFA-1500 does not have to be revised** to capture 8-digit dates for the above fields.
- **All date fields, except for item 24a,** must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On Form HCFA-1500, the space between month, day, and year is delineated by a dotted, vertical line.
- Item 24a must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24a will penetrate the dotted, vertical lines used to separate month,

day, and year. Our claims processing system will be able to process your claim if you penetrate these vertical lines. However, all 8-digit dates reported **must stay within the confines of item 24a.**

- **Do not compress or change the font of the "year" field in item 24a to keep the date within the confines of item 24a.** If you enter a continuous number in item 24a with no spaces between month, day, and year, you will not need to compress the "year" field to remain within the confines of item 24a.
- The "from" date in item 24a must not run into the "to" date field, and the "to" date must not run into item 24b.
- Dates reported in item 24a must not be reported with a slash between month, day, and year.
- If you decide to enter 8-digit dates for items 11b, 12, 14, 16, 18, 19, 24a, or 31, you must enter 8-digit dates for **all** these fields. For instance, you are not permitted to enter 8-digit dates for items 11b, 12, 14, 16, 18, 19, 31 and a 6-digit date for item 24a. The same applies to those who wish to submit 6-digit dates for these fields.

If you do not adhere to the above requirements, your claim will be returned to you as unprocessable as of October 1, 1998.

Implementation of Court Order in National Medical Care v. Shalala

On January 9, 1998, the Court issued a memorandum and an interlocutory order in *National Medical Care v. Shalala.* Essentially, the Court barred HCFA from requiring plaintiff to apply HCFA's April 24, 1995 clarification of its interpretation of the Omnibus Budget Reconciliation Act of 1993 change in the Medicare Secondary Payer (MSP) ESRD provision to services provided on or after August 10, 1993 and prior to April 24, 1995. This bulletin advises providers and suppliers of the decision that HCFA has made regarding implementation of this interlocutory order.

HCFA had previously extended until December 31, 1997 the time period during which initial claims for services, provided between August 10, 1993 and April 23, 1995 and related to the issue in this case, must be filed. Claims related to the issue are those that involve services that were provided to Medicare beneficiaries who: (a) were entitled on the basis of ESRD as well as age or disability; (b) had GHP coverage at the time the services were provided; and (c) received the services during their first 18 months of entitlement based on ESRD.

The time period for providers and suppliers to file claims for services provided between August 10, 1993 and April 23, 1995 related to the issue in the NMC case will not be extended further at this time. (HCFA never extended timely filing for services provided after April 23, 1995.) In addition, Medicare will not reopen, at this time, any claims for services provided between August 10, 1993 and April 23, 1995 where the basis for the requested reopening is related to the issue in the NMC case. Following ultimate disposition of this case, HCFA will afford all providers and suppliers an opportunity to submit initial claims affected by the ultimate orders in this case, and will provide further guidance on reopening claims.

BBA Requirement to Furnish Diagnostic Information

Pursuant to Section 4317(b) of the Balanced Budget Act of 1997 (BBA), physicians and non-physician practitioners (including physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, and clinical social workers) will be required to provide diagnostic information upon ordering certain items or services provided by another entity, effective January 1, 1998. This section of the BBA amends 1842(p) of the Social Security Act (SSA).

This amendment specifies that in the event that the Secretary of Health and Human Services or a fiscal agent of the Secretary (i.e., carriers) requires diagnostic information or other medical information to make payment for an item or service provided by an entity (i.e., supplier or provider), then the physician or practitioner will be required to provide the information requested. This requirement includes any diagnostic information specified by a carrier's medical policy. Affected items and services include, but are not limited to; Durable Medical Equipment (DME), prosthetic devices and orthotic devices as specified in section 1861(s) of the SSA.

Consolidated Billing

Section 4432(b) of the Balanced Budget Act of 1997 (BBA) requires consolidated billing for Skilled Nursing Facilities (SNFs). Under the consolidated billing requirement, the SNF must submit **ALL** Medicare claims for **ALL** the services that its residents receive (both Part A and Part B services), except for certain excluded services.

SNFs will no longer be able to "unbundle" certain services to an outside supplier that can then submit a separate bill to the Part B carrier. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier in which the SNF (rather than the supplier) bills Medicare, Part A.

General Billing Information for Transition

A transition period from July 1, 1998 through December 31, 1998 is available for those SNFs that will not have the systems and billing capability to submit claims to the intermediary for all the services that their residents receive effective for services and supplies rendered on or after July 1, 1998.

Beginning January 1, 1999, suppliers will no longer be permitted to bill the Part B carrier or the DMERC for supplies and services rendered to residents of a SNF. The SNF must bill the intermediary.

During this transition period, suppliers may continue to bill the DMERC as appropriate.

We encourage you to become familiar with any changes that will occur with your SNF clients.

For questions or any additional information, please contact your SNF customer or Part A intermediary.

1998 UPIN Directory Available

Please contact your local Part B carrier who received a limited supply of copies. If hard copy versions are no longer available or you are interested in obtaining your copy on CD ROM, please contact the Government Printing Office at (202) 512-1530. Each copy of the UPIN listing is $18.00.

Electronic Data Interchange

Region A's Accelerate Software is Millennium Ready

The Accelerate program you have presently is millennium ready. No updates to the program are required. If you do not currently have the Accelerate software package and are interested in a cost effective and accurate method to submit your DMEPOS claims electronically, please call the EDI Unit at (717) 735-9429.

Administrative Simplification List Serve Available

This list serve will notify you when a document is published and/or posted regarding the administrative simplification provisions of the HIPAA.

Please note that instructions for subscribing to this list serve are now available at:

http://www.hcfa.gov/medicare/edi/edi.htm

Letter on Health Insurance Portability and Accountability Act (HIPAA)

Dear Colleague:

What impact does the Health Insurance Portability and Accountability Act of 1996 have on you?

More than you may have realized.

The Administrative Simplification provisions of the Act mandate that the Secretary of Health and Human Services adopt national standards for the electronic transmission of health care transactions. **All** health plans and clearinghouses and those providers who use electronic data interchange must meet these standards. That's right - not just the Medicare and Medicaid programs but **all** health plans. The provisions also require national standards for medical code sets; standard identifiers for providers, health plans, employers, and individuals; and security and privacy standards.

A wide range of organizations and individuals will be affected, including those that:

- Pay health care claims or coordinate benefits across payers.
- Submit claims to health plans.
- Submit medical encounter data to managed care plans.
- Enroll employees in health plans.
- Pay premiums to health plans.
- Conduct authorized referrals.
- Provide prior authorization for services.
- File first reports of injury for worker's compensation.
- Query insurance eligibility or claim status.

The standards for these health care transactions, code sets, identifiers, and security are scheduled to go into effect 2 years after they are adopted by the Secretary. (Small health plans have one extra year). At that time, organizations will need to be able to accept standard electronic transactions from their customers. In addition, the Secretary has made recommendations to Congress for privacy legislation to protect individually identifiable health information. Standards for claims attachments will also be adopted, and will be proposed in the next year.

There will be clear benefits to those who use electronic transactions. With a national standard, the same claim can be sent to any insurance company for payment, greatly simplifying claims submission for providers. And payers will know exactly what a claim from any provider will look like - it will be the same as claims from other providers.

The Department of Health and Human Services (DHHS) and other Federal and State agencies have been hard at work since the passage of the Act in August 1996. After extensive consultation with technical and professional organizations, a series of standards is ready to be proposed. The standards to be adopted will build on the voluntary consensus standards already developed by the private sector.

We have received extensive industry input to date but are continuing to look for comments on these standards. The Notices of Proposed Rule Making (NPRMs), the first official publications of the proposed standards, are expected to be published in the *Federal Register* shortly. In addition, the NPRMs will be available from the Department's Administrative Simplification World Wide Web site at:

http://aspe.os.dhhs.gov/admnsimp/

Because you will be directly affected by these standards, we urge you to carefully read the proposed rules and provide your comments to the addressees noted in the NPRMs. These comments will be critical in determining the final set of standards to be adopted. We ask that associations work with their members to provide input to us.

DHHS has arranged for the implementation guides for proposed standards to be available on the World Wide Web. The guides can be downloaded free of charge from the Washington Publishing Company Web site at:

http://www.wpc-edi.com/HIPAA

Additionally, now is the time for you to begin planning for implementation of these new standards. This is an opportunity to move from paper transactions to electronic transactions, to move from proprietary systems to open systems - to move to national standards.

We urge you and your members to begin the process of implementation by discussing these transactions with your business partners and with the vendors that provide these services.

So watch the *Federal Register*, watch the Web site, and start the implementation process. Now is the time.

Yours truly,

Co-Chairs
HHS Data Council, Committee on Health Data Standards
Bill Braithwaite Karen Trudel

Medical Policy

Expanded Coverage of Blood Glucose Monitors and Testing Strips

The BBA includes several new provisions relating to Medicare beneficiaries who are diagnosed with diabetes. This instruction is to implement the provision on expanded coverage of blood glucose monitors and testing strips.

Currently, Medicare only covers blood glucose monitors and test strips for beneficiaries with diabetes who are insulin-dependent. BBA §4105 expanded coverage to include monitors and test strips for all diabetic beneficiaries. Beginning July 1, 1998, Medicare will cover blood glucose monitors and test strips for beneficiaries with diabetes without regard to whether a beneficiary has Type I or Type II diabetes or whether a beneficiary is insulin-dependent or non-insulin dependent.

Medicare pays for medically necessary blood glucose monitors, blood testing strips, and lancets subject to conditions and limitations. A written physician order must be received by the supplier prior to delivery of the item.

- **Blood Glucose Monitors**.—Medicare pays for blood glucose monitors if the physician treating the beneficiary's diabetic condition documents that the beneficiary or care giver is capable of being trained to use the monitor and the beneficiary or care giver has completed training to self-monitor the diabetes. The monitor must be designed for home use, not institutional use.
- **Test Strips and Lancets for Insulin-Treated Diabetes**.—Medicare will pay for up to 100 test strips and 100 lancets *every month* for use by a beneficiary who is an insulin-treated diabetic. Medicare will pay for more than 100 test strips and 100 lancets per month for the insulin-treated beneficiary if the physician documents the beneficiary's medical need. The supplier of the test strips and lancets maintains the physician's order in its records.
- **Test Strips and Lancets for Non-Insulin-Treated Diabetes**.—Medicare will pay for up to 50 test strips and 50 lancets every *2 months* for use by a beneficiary. Medicare will pay for more than 50 test strips and lancets every *2 months* for the non-insulin-treated beneficiary if one of the following indicators is present:
  - Management of medical condition by adjusting therapy and/or oral agents; or
  - Detection of hypoglycemia when symptoms are present.

'Ask the Doc' Cancelled

The last two issues of *DMERC Medicare News* introduced a new column called 'Ask the Doc.' Since that time we have received only two questions from suppliers. While these were valid questions, a response to the supplier community at large was not necessary. Therefore, due to such limited response, 'Ask the Doc' is being withdrawn as a regularly featured newsletter article.

New Code for Alprostadil Urethral Suppository

Effective for claims with dates of service on or after July 1, 1998, the following national temporary 'Q' code has been established for use in reporting the drug listed below.

Q0182-Alprostadil, Urethral Suppository, Administered Under Direct Physician Supervision, Excludes Self-Administration

Claims for Q0182 are submitted to the Local Carrier for processing.

New Codes for Heavy Duty Walkers

Two new codes have been established for Heavy Duty Walkers. The new codes are:

K0458-Heavy Duty Walker without wheels, each

K0459-Heavy Duty Wheeled Walker, each

Heavy Duty Walkers are defined as those capable of supporting patients who weigh more than 300 lbs. It may be fixed height or adjustable height.

K0458 and K0459 are **effective** for claims with dates of service **on or after 7-1-98**. These codes are in the Inexpensive and Routinely Purchased (IRP) payment category.

Claims for K0458 and K0459 *must* include documentation of the patient's weight. If the patient weight is less than 300 lbs. or not included on the claim, payment will be based on the allowance for the least costly medically appropriate alternative, E0130 or E0141, respectively.

New Code for Heavy Duty Commode Chair

A new code has been established for extra wide/heavy duty commode chair. The new code is:

K0457-Extra Wide/ Heavy Duty Commode Chair, each

K0457 is **effective** for claims with dates of service on or after **7-1-98.** K0457 is in the Inexpensive and Routinely Purchased (IRP) payment category.

Extra Wide/ Heavy Duty Commodes are defined as those that have a width of 23 or more inches. This type of commode is also capable of supporting patients who weigh 300 lbs. or more.

Claims for K0457 must include documentation of the patient's weight. If patient weight is less than 300 lbs., payment will be based on the least costly medically appropriate alternative, E0163.

If the patient has a body configuration that requires extra width but weighs less than 300 lbs., a commode with detachable arms (E0165) is covered if other coverage criteria are met.

For dates of service prior to 7-1-98, claims for extra wide/heavy duty commodes are billed using E1399-Miscellaneous DME. Documentation must include the manufacturer, brand name/model of the commode, and information of why it is necessary for the patient.

For dates of service on or after 7-1-98, K0457 must be used when submitting claims for an extra wide/heavy duty commode chair to the DMERC.

New Codes for Power Add-ons for Manual Wheelchair Bases

Two new codes have been developed for power add-on attachments to convert manual wheelchairs to power products. The new codes which are **effective** for dates of service on or after **July 1, 1998** are:

K0460-Power add on, to convert manual wheelchair to motorized wheelchair, joystick control

K0461-Power add on, to convert manual wheelchair to power operated vehicle, tiller control

Power wheelchairs, codes K0010-K0014, are not to be used for manual wheelchairs with power add-ons.

For dates of service **prior to** July 1,1998, power add-ons are to be billed using the code K0108 or E1399. For dates of service **on or after** July 1, 1998, power add-ons are billed using K0460 or K0461. Documentation must include:

- Motorized Wheelchairs CMN 02.03A signed and dated by the treating physician.

In addition to the above information, for claims with dates of service **prior to** July 1,1998, claims coded using K0108 or E1399 must also include a narrative description of the power add-on including the manufacturer, brand name, and model number of the item.

New Code for Heavy Duty Hospital Beds

Effective for claims with dates of service on or after July 1, 1998, a new code has been established for Heavy Duty Hospital Beds. The new code is:

K0456-Hospital Bed, Heavy Duty , Extra Wide, Semi-Electric (head and foot adjustment) with any type side rails, with mattress

K0456 is a hospital bed that is capable of supporting a patient who weighs more than 350 lbs. but less than or equal to 600 lbs. Initial claims for K0456 must be accompanied by a Hospital Bed CMN 01.02 that must include the patient's weight. If coverage criteria are not met or documentation is not included on the CMN, payment will be based on the least costly, medically appropriate alternative, E0260.

As stated in the December 1997 *DMERC Medicare News*, claims with dates of service prior to July 1,1998 are to be submitted using the miscellaneous code E1399. For claims with dates of service on or after July 1,1998, HCPCS code K0456 must be used when submitting claims for heavy duty hospital beds to the DMERC.

If the patient weighs more than 600 lbs., code E1399 -Miscellaneous, DME is used. Initial claims *must* be accompanied by:

- a Hospital Bed CMN 01.02 that must include the patient's weight, and
- the manufacturer and model / product name / number of the bed, and
- information which describes the necessity for the bed.

If coverage criteria are not met or documentation is not included on the CMN, payment will be based on the least costly, medically appropriate alternative, E0260.

These beds will be considered capped rental items. Payment will only be made on a rental basis. The appropriate modifier (KH, KI, KJ) must be used and the rent / purchase option must be offered in the tenth rental month, as with all capped rental items.

A6261 (K0261), A6262 (K0262) Documentation Requirements

HCPCS code A6261, formerly K0261, and code A6262, formerly K0262, are codes used to describe wound fillers that do not fit existing surgical dressing code categories. For wound fillers, there must be wound documentation included with the claim. Since the "Not Elsewhere Classified Codes" used for various wound filler products may represent a wide variety of diverse properties, including weight, consistency, and amounts, documentation is needed for each individual wound.

A6261-Wound filler, gel/paste, per fluid ounce, not elsewhere classified is the appropriate code to use for claims with dates of service on or after 01-01-97.

K0261-Wound filler, not elsewhere classified, gel/paste, per fluid ounce is the appropriate code to use for claims with dates of service prior to 1-1-97.

A6262-Wound filler, dry form, per gram, not elsewhere classified is the appropriate code to use for claims with dates of service on or after 01-01-97.

K0262-Wound filler, not elsewhere classified, dry form, per gram is the appropriate code to use for claims with dates of service prior to 1-1-97.

In addition to the documentation requirements outlined in *DMERC Regional Medical Review Policy for Surgical Dressings*, claims must also include documentation of:

- the total number of wounds on which the wound filler is being used, and
- wound size(s) for each wound(s) on which the wound filler is being applied, and
- the type of secondary dressing used in conjunction with the wound filler, and
- documentation of the amount of wound drainage.

Claims submitted without the above documentation will be denied as not medically necessary.

Proper Use of HCPCS Code A9270

HCPCS code A9270 is to be used only for non covered items or services when a code does not exist to define the item or service. A9270 is used to describe those items or services non covered by Medicare or when the Coding Guidelines section of a Regional Medical Review Policy instructs usage of A9270 for a particular item or service. When a HCPCS code exists for a supply, material, injection, or service, the designated code must be used.

Usage of this code in other circumstances to achieve reimbursement from the beneficiary or secondary insurance may be considered misrepresentative or abusive billing.

From our data analysis and reports from secondary insurers in Region A, it has come to our attention that suppliers are using code A9270 in order to obtain a "coverage" denial for situations that may be denied by Medicare as not medically necessary. This causes the liability for payment to be erroneously placed on the secondary insurer or the beneficiary.

Examples of situations where A9270 is used **improperly**:

- Billing for items classified as DME, such as wheelchairs, when they are being supplied in a place of service where DME is not covered (e.g., POS 31).
- Billing for items using A9270 which do not meet the coverage and payment criteria outlined in medical policy even though a valid HCPCS code exists to define the item.
- A9270 is being used to bill for wheelchairs and repairs to wheelchairs which are used as back-ups.

When a code exists to define an item or service, that HCPCS code must be used.

Allowable Fees

The following are the 1998 allowables for the above codes:										
HCPCS CODE	**CT**	**DE**	**MA**	**ME**	**NH**	**NJ**	**NY**	**PA**	**RI**	**VT**
K0456RR	289.94	283.60	289.94	289.94	289.94	272.63	281.72	278.42	246.45	289.94
K0457NU	143.95	143.95	143.95	143.95	143.95	143.95	143.95	143.95	143.95	143.95
K0457RR	14.46	14.46	14.46	14.46	14.46	14.46	14.46	14.46	14.46	14.46
K0457UE	107.96	107.96	107.96	107.96	107.96	107.96	107.96	107.96	107.96	107.96
K0458NU	121.19	121.19	121.19	121.19	121.19	121.19	121.19	121.19	121.19	121.19
K0458RR	12.13	12.13	12.13	12.13	12.13	12.13	12.13	12.13	12.13	12.13
K0458UE	90.88	90.88	90.88	90.88	90.88	90.88	90.88	90.88	90.88	90.88
K0459RR	30.59	30.59	30.59	30.59	30.59	30.59	30.59	30.59	30.59	30.59
K0459UE	229.51	229.51	229.51	229.51	229.51	229.51	229.51	229.51	229.51	229.51
K0460RR	238.39	233.18	238.39	238.39	238.39	224.17	231.65	228.94	202.63	238.39
K0461NU	1822.36	1549.01	1679.63	1749.02	1822.36	1549.01	1693.84	1549.01	1677.25	1822.36
K0461RR	169.39	143.98	167.96	169.39	169.39	144.04	169.39	143.98	167.72	169.39

New Code for Temporary Replacement of Patient Owned Equipment Which Is Being Repaired

Effective for claims with dates of service **on or after July 1, 1998**, a new code has been established for the temporary replacement of patient owned equipment which is being repaired. The new code is:

K0462-Temporary Replacement for Patient Owned Equipment Being Repaired, any type

One month's rental is covered if the patient owned equipment is being repaired. A claim for K0462 must include a narrative description of the equipment being used as a temporary replacement, manufacturer, brand name / model name / number of the temporary replacement item and statement defining the medical necessity of the temporary replacement item for the particular patient. Claims without this information will be denied as not medically necessary.

Oral Anti-Cancer Drug Codes - Update

The following NDC numbers have been **added** to the list of Oral Cancer Drug Codes **effective** for claims with dates of service on or after **01-01-97**:

NDC# 62701-0940-36: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by Supergen

NDC# 62701-0940-99: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by Supergen

The following NDC number was effective for claims with dates of service on or after 10-01-97:

NDC# 00677-1610-01: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by URL

The NDC number must be used for submitting claims for these items to the DMERC.

The following NDC numbers have been discontinued. This is effective for claims with dates of service on or after 1-1-98:

NDC# 51079-0670-86: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by UDL

NDC# 51079-0670-87: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by UDL

NDC# 51079-0670-88: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by UDL

NDC# 51079-0670-89: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by UDL

NDC# 58469-3998-30: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by Roxanne

NDC# 00405-4643-36: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by Roxanne

NDC# 00405-4643- 01: Methotrexate 2.5mg oral 1 TAB, per unit manufactured by Roxanne

Enteral Nutrients Product Classification List - Update

The following codes have been added to the Product Classification List for Enteral Nutrients. The products are:

Category II- B4151	ProSobee
Category III-B4153	Peptamin 1.5 Diet
Category IV- B4154	Oxepa

Surgical Dressings Product Classification List- Update

The following products have been added to the Surgical Dressings Product Classification List:

Manufacturer	Product	HCPCS Code
3M	Medipore H Soft Cloth Surgical Tape	A6265
Acrymed	Medipore Adhesive Cover	A6265
Baxter	Intact	A6234-A6239
Braun	Fybron Calcium Alginate Dressing (cover)	A6196-A6197
	Fybron Calcium Alginate Dressing (filler)	A6199
	Hyfil Wound Gel	A6248
Brennen	Dermafit	A4460
	Elastinet	A4649
	NovaGel Silicone	A6025
	Sterile Saline Solution Spray	A6260
Cica Care	Silicone Gel Sheeting	A6025
Convatec	Combiderm Non-Adhesive Dressing	A6235
	Dermagran Hydrophylic Dressing	A6242-A6247
	Dermagran Ointment	A4649
	Dermagran Wet Dressing	A6228-A6230
	EpiView	A6257-A6259
	SafGel	A6248
Cush	Protect-All Dressings	A6219-A6220
GeriCare	Curative Amorphous Hydrogel Dressing	A6248
	Curative HydroGel Gauze Dressing	A6242
Hyperion Medical	Hyperion Advanced Alginate Dressings (cover)	A6196-A6197
	Hyperion Advanced Alginate Dressings (filler)	A6199
	Hyperion Advanced Film Dressing with Fixed MTVR	A6257-A6258
	Hyperion Advanced Dressing withVariable MTVR	A6257-A6258
	Hyperion Hydrophillic Impregnated Gauze	A6242-A6244
Southwest Technologies, Inc.	Elasto-Gel Plus	A6242-A6244
Tapeless Technologies, Inc.	Tapeless Secondary Dressings	A4649

Wheelchair Bases Product Classification List- Update

The following products were added to the Wheelchair Base Product Classification List:

Manufacturer	Model Name/Number	HCPCS Code
21st Century Scientific	Bounder	K0011
	Big Bounder	K0014
	Bounder Plus	K0014
Everest and Jennings	New Traveler (K) (L)	K0006
	Metro XD	K0007
	Navigator	K0011
Hoveround	HVR 1	K0001
	HVR 2	K0002
	HVR 3	K0003
	HVR 6	K0006
	HVR 7	K0007
Invacare	Action P7E	K0012
Merits	Travel Ease 20”	K0006
	Travel Ease 22”	K0007
	Travel Ease 24”	K0007
Optima	EcoStar	K0003
	Premium	K0003
	Ultralight	K0004
	Universal	K0004
	Sport One	K0005
	Super Junior	K0009
	Super One	K0009
Pillar Technology, Inc	Deluxe Snappy (TE88WS)	K0011
	Snappy (TE888W)	K0011
Pride	Jazzy 1120	K0011
Quickie	Breezy 500	K0004
	Breezy 510	K0004
	P-120	K0012
Teftec Corporation	Omega Trac	K0011
Wheel Ring, Inc.	Taurus	K0003

Footnotes: (K) Code seat width of 19 or 20 inches separately using K0057.
(L) Code seat width 18 inches separately using K0108.

Miscellaneous

Attention: Ambulance Suppliers and Beneficiaries

Forms HCFA-1491 and HCFA-1490S are now available electronically on the HCFA homepage. To access these forms from the Internet, enter the following:

http://www.hcfa.gov/medicare/edi/edi5.htm

Form HCFA-1491 (Request for Medicare Payment-Ambulance) is used to bill Medicare, Part B covered ambulance services. Note that Medicare, Part B covered ambulance services can be billed on Form HCFA-1500 too.

Form HCFA-1490S (Patient's Request for Medicare Payment) is used by Medicare beneficiaries for billing Medicare covered services. Note that providers and suppliers are required by law to submit Medicare claims on behalf of a beneficiary. If a beneficiary wishes to submit a claim, he or she must do so on Form HCFA-1490S. A beneficiary must also attach to Form-1490S any bill(s) he or she receives from providers / suppliers.

Feel free to download or copy these forms from the HCFA homepage.

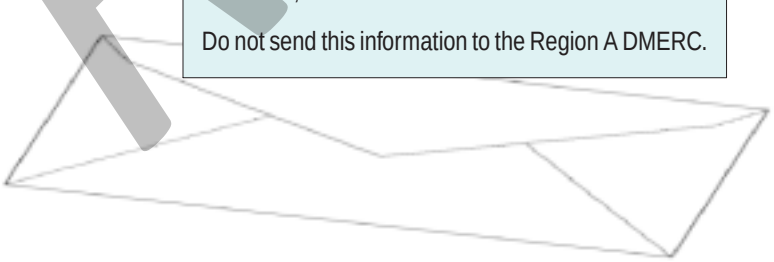
Supplier Change of Telephone Number

Changes to the supplier address information indicated on the original application for a supplier number must be reported to the National Supplier Clearinghouse (NSC). Changes must be submitted in writing on the supplier's company letterhead within 35 days following the actual revision. This includes any revisions to the supplier's telephone number listing.

Please submit notification of such changes to:

National Supplier Clearinghouse
Palmetto Government Benefits Administrators
PO Box 100142
Columbia, SC 29202-3142

Do not send this information to the Region A DMERC.



Frequently Asked Questions January - March 1998

1. *Why am I receiving denials for maintenance and servicing on capped rental items? (A/C D01, D02)*

   Denial of maintenance and service on capped rental equipment is the result of either billing an incorrect maintenance and service date or billing for maintenance and service when an incomplete capped rental cycle exists. A complete capped rental cycle consists of fifteen paid rental months. Maintenance and service may be billed once every six months following the end of the fifteenth rental month.

2. *Why are my claims for rental equipment (hospital beds, wheelchairs) denied as same or similar equipment? (A/C 307)*

   Same or similar equipment denials occur when equipment exists on the beneficiary's history that is same or similar to the equipment that is currently being denied. This type of denial can be resolved by determining what type equipment the beneficiary has or previously had, if the equipment was purchased by the beneficiary, if the equipment was returned to the supplier and what conditions or changes in the beneficiary's medical history warrant the new equipment.

3. *Why are my claims for oxygen rentals denied stating the medical criteria were not met? (A/C 322, 324)*

   Claims for oxygen equipment are denied as not meeting the medical criteria if the Certificate of Medical Necessity (CMN) does not meet policy requirements for coverage. This can be the result of missing or invalid information on the CMN.

4. *Are diabetic supplies covered for non-insulin dependent diabetics?*

   The current policy covers insulin dependent diabetics only. The tentative date for coverage for non-insulin dependent diabetics is July 1, 1998.

5. *Are syringes and insulin covered by Medicare?*

   These are non-covered.

6. *Why are my claims for rental of an Enteral pump (B9002) denied as being capped out? (A/C 311)*

   The Enteral pump is a capped rental item. When 15 paid rental months exist on the beneficiary's history and rental billing continues, claims will be denied.

7. *Why are my claims for the rental of a nebulizer compressor denied as not meeting the medical criteria? (A/C 531)*

   Claims which do not meet the policy requirements based on diagnosis and medical necessity are denied as not meeting the medical criteria.

8. *Why are my claims for nebulizer accessories denied as not meeting the medical criteria? (A/C 531)*

   Claims for nebulizer accessories which do not meet the policy requirements based on diagnosis and quantities of supplies billed in excess of the usual maximums, without additional medical documentation, are denied as not meeting the medical criteria.

9. *What is the Surety Bond and when did it become effective?*

   The Surety Bond is a new supplier standard effective in 1998. The supplier community will receive notice from the National Supplier Clearinghouse (NSC) with instructions as to specific requirements. The supplier community is required to do nothing until official notice is received from the NSC.

10. *When are the new CMNs effective?*

    The new CMNs were effective October 1, 1997. They have replaced the previous version and became mandatory for claims submitted on or after April 1, 1998.

11. *Why are my claims denied for an invalid place of service? (A/C 574)*

    The place of service used in item 24b of the claim form should be the patient's residence. Items are eligible for coverage by the DMERC when the place of service is representative of the patient's residence. Neither Pos 11 nor 99 can be considered the patient's residence.

12. *Are there new oxygen guidelines effective with the new oxygen CMN?*

    The oxygen policy did not change, only the CMN format has changed. The 484.2 version of the CMN became mandatory for claims submitted on or after April 1, 1998. The only change is that the patient must be tested in a chronic stable state as an outpatient or within two days prior to discharge from an inpatient facility to home.

13. *Why are my claims for enteral nutrients downcoded to a least costly alternative product when the CMN is valid?*

    A valid CMN would justify the need for Enteral coverage, but does not necessarily justify the need for the special nutrient product provided. Additional documentation is needed to support the medical necessity of the special product in the individual case. Claims are downcoded when there is insufficient documentation or medical justification submitted with the claim.

Notes

Oxygen 484.2 CMN Clarification Supplier Notice 98-04

(March 23, 1998)

Numerous questions have been directed to Customer Service and Professional Relations regarding the revised Oxygen 484.2 Certificate of Medical Necessity (CMN). This new form follows the four section format of the other DMERC CMNs. The 484.2 CMN is mandatory for claims received on or after April 1, 1998. The following serves as clarification and does not replace medical policy or the 484.2 instructions previously published.

- **Section A** may be completed by the supplier. This section contains an area to indicate patient height and weight. This information is optional. The patient's height and weight are required for certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies as specified in the particular medical policy. The HCPCS codes for the equipment are required in Section A.
- **Section B** contains the medical necessity information. As with all version .02 CMNs, if someone other than the physician completes this section, that person must print their name, title, and employer. **Section B may not be completed by the supplier.**
  - ***Question 1*** must contain an arterial blood gas test and/or an oximetry test. If both tests were performed on the same day, both test results must be recorded on the CMN. The arterial blood gas test result will determine coverage.
  - ***Question 2*** must be answered. Please refer to the "Oxygen Policy - Testing/Documentation Requirements" found on page 18 of the July 1997 *DMERC Medicare News.* If the physician answers 'No' to this question, the supplier may send additional information from the physician.
  - ***Question 3*** must be answered according to the condition of the test. This question does not pertain to whether or not the patient was using oxygen during the test. If the patient was tested while on oxygen, the supplier should include that information as additional documentation with the claim.
  - ***Question 4*** must contain the complete name and address of the physician/provider who performed the test.
  - ***Question 5*** concerns portable oxygen coverage and must be answered.
  - ***Question 6*** must contain the highest liter flow ordered by the physician.
  - ***Question 7*** must contain test results when the patient was tested on 4 iters per minute (lpm) of oxygen, if the highest flow rate ordered is above 4 liters per minute. Otherwise, the physician should enter zeros in this space.
  - ***Questions 8, 9, and 10*** must be answered even though Group II coverage may not be applicable.
- **Section C** must contain: a narrative description of all items, accessories and options ordered; and the supplier's charge and the Medicare Fee Schedule allowance for each item, accessory and option. Additional information from the physician's order (i.e., liter flow rate), may be included in Section C. Section C must be completed before the form is sent for physician completion.
- **Section D** must be signed and dated by the physician.

Nebulizer Codes - E0565, K0269, K0501 Supplier Notice 98-05

(April 3, 1998)

The December 1997 issue of *DMERC Medicare News,* page 3, contained an article concerning the above listed codes. The purpose was to inform suppliers that codes **E0565, K0269,** and **K0501** would no longer be valid for claim submission to the DMERC as of April 1, 1998.

Since this article was published, the DMERC has been informed by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) that various manufacturers have presented product specifications which match the description of one of these codes**. Therefore, no action will be taken to invalidate these codes as previously published.**

Billing Reminder - CPM Supplier Notice 98-06

(April 15, 1998)

The Continuous Passive Motion (CPM) device for the knee - E0935 is the only such device eligible for coverage and reimbursement through the DMERC. The following criteria must be met:

- The device must be prescribed by a physician. *(See requirements for acceptable orders; page 12-36, 37 of the Region A Supplier Manual.)*
- The patient must have undergone a total knee replacement.
- The use of the device must commence within 2 days of the date of surgery.
- Coverage is limited to that part of a 21-day period, beginning with the date of surgery, during which the device is used in the patient's home.

Please document the following dates on the claim:

- Date of surgery
- Date CPM therapy began
- Date of discharge

Retraction Notice Supplier Notice 98-07

(May 20, 1998)

A Special Issue of the *DMERC Medicare News,* Number 37, May 1998 entitled "*Special Notice to Suppliers"* was recently published and distributed with regard to certain HCFA mandated changes to reduce Medicare program costs.

The segment titled "Provider Reimbursement" *WILL NOT* be implemented by the Region A DMERC. Please disregard that particular portion of the notice.

The other cost saving initiatives found in the notice are valid and effective as published.

DMERC Medicare News

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