DMERC

Medicare

News

DMERC Region A Service Office • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800 • Phone (570) 735-9445 • www.medicare-link.com
Number 44 • June, 1999

Region A DMERC Announcement

We are pleased to announce that Jeanne Mariani R.N., B.S.N., M.H.A. has become Director of the Region A DMERC effective June 21, 1999. Our current Director, Fred Larsen, will support Jeanne to ensure a smooth transition of leadership.

Jeanne has an extensive background in healthcare management; her previous experience includes Vice-President of Nursing, and also Chief Operating Officer, Mercy Hospital, Scranton, PA of the Mercy Health System, Cincinnati, OH.

Having joined the DMERC in 1997, as manager of Medical Review / Utilization Review, Jeanne has contributed significantly in focusing and enhancing the efforts of the DMERC Medical Review Team.

Jeanne looks forward to continuing and strengthening our relationship with suppliers, and she is interested in developing new ways to provide quality service to the Medicare community.

Government Operations Receives a Certificate of Appreciation for Y2K Readiness from HCFA

Ms. Nancy-Ann Min DeParle, Administrator for the Health Care Financing Administration (HCFA) recently presented a certificate of appreciation to the staff of Government Operations for their achievements in preparing for Year 2000. Government Operations, which is part of Uniprise Operations, processes over 65 million Medicare fee-for-service claims annually under four contracts with HCFA and the Railroad Retirement Board.

The Certificate is in recognition of the hard work and dedication to meet the Year 2000 readiness requirements of the HCFA Medicare Program. While there is still much work to be done before the millennium, being recognized for attaining initial Y2K readiness is a significant accomplishment. Great Job!

What is the Y2K Problem?

- Many computer systems store only the last two digits of a four-digit year. For example, the year “1999” is shown as “99.”
- Some programs may interpret the Year “00” as 1900, instead of 2000.

What must be done to correct this problem?

- The two primary options are either to rewrite the program code to translate two-digit years into the century or to expand date fields to accommodate four-digit years.
- Microchips in electronic equipment might need to be replaced with new ones containing the corrected date logic.

United HealthCare Region A DMERC has developed a plan to ensure Y2K readiness and compliance during fiscal year ’99. Each provider business or provider-related company must evaluate their business computer chip-controlled work functions for two-digit year date errors; correct any problems identified; then, test the corrections. Businesses are encouraged to develop a contingency plan. United HealthCare will seek to educate and inform providers, computer vendors, billing services, and other organizations with Y2K materials and provide whatever assistance we can offer.

(continued from page 1)

Additional Y2K information can be found from the following resources:

Y2K Website Resources:

United HealthCare Region A DMERC	www.medicare-link.com
HCFA Y2K-related Information	www.hcfa.gov / y2k
Year 2000 tools	www.hp.com / year2000 / help / cure.html
Latest Information on Y2K	www.y2kjournal.com
Electronic Data Interchange	www.hcfa.gov / medicare / edi / edi.htm
Contingency Planning	www.millennia-bcs com
Y2K Compliance Information	www. Mitre.org / technology / y2k
Information available from the Federal government and its contractors	www.fda.com
Y2K Information Center	www.year2000.com

Region A DMERC Y2K Hotline: 570-735-9689

Internet Addresses

Region A DMERC Office **www.medicare-link.com**

HCFA Office **www.hcfa.gov**

In This Issue

June 1999

Year 2000 Testing via the Bulletin Board System

As of July 1, 1999, electronic claim vendors and providers may begin testing on our asynchronous Bulletin Board System (TBBS). The purpose of our Year 2000 (Y2K) testing is to confirm the successful transfer of claim data with future dates between your billing system and our Medicare claim collection facility. Although this testing does **not** certify your system for Y2K compliance, our Y2K test will show what will happen with claims created by your renovated billing system. You'll also find more information about Y2K on our web site at www.medicare-link.com/y2k/contents.htm. We **strongly** encourage you to test your system after it has been renovated for Y2K.

To submit Y2K test claims, please follow the steps listed below.

1. Complete and fax or mail the attached questionnaire to the appropriate EDI department. After the EDI Department establishes your testing setup, you will be notified, either by phone or fax, of when you can send your initial test file and of the bulletin board phone number.

2. Our Y2K test system telephone number will be supplied at the time of setup. The test system will be available July 1, 1999 until January 20, 2000. Our test system will be set at the current date plus 364 days (e.g., July 7, 1999 will be processed as July 5, 2000).

3. When you access the system for the first time, use the word "new" for the initial logon password. As part of the logon process, reset your password. The test file you create should contain between 15 to 30 claims.

4. We suggest that you include the following dates in your test: 12/31/1999, 01/01/2000, leap-year 02/28/2000, 02/29/2000, and 03/01/2000.

5. Files submitted by 4:00 PM on any business day will be processed by noon the next business day. Please remember to download and review your Reject Report.

If you have any questions, please contact the appropriate EDI Department.

Region	*Telephone Number*
Connecticut	(203) 639-3160
Minnesota	(612) 885-2889, (612) 885-2882 or (612) 885-2811
Mississippi	(601) 977-5631 after June 28, 1999 (804) 327-7660
Virginia	(804) 327-2233
DMERC	(570) 735-9429
RRB Georgia	(706) 855-3078

UNITEDhealthcare®
United HealthCare Insurance Company
450 Columbus Boulevard. • P. O. Box 150450 • Hartford, CT 06115-0450
A HCFA Contracted Carrier

Y2K Testing Questionnaire

Company Name: ______________________________

Current Submitter Number: ______________________________

Address: ______________________________

City: ________________ State: __________ Zip: __________

Phone: ________________ Fax: ________________

Contact Name: ______________________________

Type of Format: NSF Version: __________ ANSI Version: __________

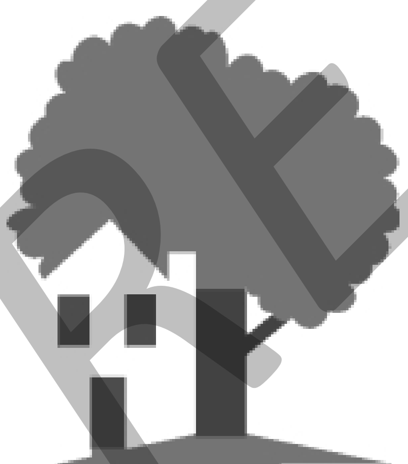
✂ -

Mail or fax to:

DMERC Region A
United HealthCare Ins. Co.
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

Fax: 570-735-9510

Attention: Rural Medicare Suppliers



As the year 2000 approaches, concerns about Y2K systems problems become more prevalent. At United HealthCare, we are taking steps to ensure our systems can make a smooth transition into the next century and beyond.

As part of that effort, we are publishing this article as a way to reach our Rural Medicare providers and vendors to remind you of the importance of examining your own computer systems with respect to potential Y2K problems. This past January, Region A DMERC mailed an informational letter and Y2K check lists to all vendors and suppliers in our region. This information can be found on our website: www.medicare-link.com. You can also find Y2K information on the previous pages of this newsletter.

Please take the time to read the Y2K material carefully. The time you spend in preparation now can save you a great deal of time and frustration in the future.

Professional Relations

Government Claim Payment Audit Scheduled for This Year

Office of Inspector General

As you are aware, the Medicare Program requires all providers to maintain appropriate documentation to support claims for services rendered to Medicare beneficiaries. The Department of Health and Human Services Office of Inspector General (OIG) will be conducting an audit of Medicare claims paid during July 1999 through September 1999. This effort results in the calculation of the National Medicare Error Rate, which reflects on all of us. Your claims may be included in this sample. If so, you will receive requests for medical documentation to support payments made for these claims. We expect these requests to be made between October 1999 and December 1999.

The sampled claims and supporting documentation will then be reviewed to ensure that all services were medically necessary and appropriate and that payments were made in accordance with Medicare reimbursement policies. Normal processes will be followed for erroneous payments.

It is important to remember that the error rate is not revised, once published. Please work with us to ensure we get all the documentation necessary at the onset of this process. If you receive a request for documentation relative to this audit, we urge you to respond timely with all documentation requested. Incomplete documentation or lack of a timely response will also result in retroactive denial of payment, and a refund will be requested.

Get Your Supplier Notices and Alerts via Email

The Region A DMERC is pleased to announce the availability of our listserve (an electronic mailing list). Once subscribed to our listserve, you will receive supplier notices and supplier alerts via email as they are issued.

To subscribe to the Region A DMERC listserve, send an email to **commands@lr.listserve.com** with the words **SUBSCRIBE DMERCA** in the body of the message.

The e-mail must *not* contain a subject or any other text in the message. You will receive a confirmation by the listserve if you sent the email properly.

For more detailed instructions, visit our web site at www.medicare-link.com/dmerc.

DMERCs Attend Future Show

UNITEDhealthCare, Region A DMERC, in association with the other three DMERCs, recently participated in the HME Future Show, which was held May 10-12, 1999 at Bally's Casino Hotel, Las Vegas, Nevada.

This is the 3rd consecutive year that the four DMERCs shared a booth at the Future Show. The Future Show is a mid-year buying, learning, and networking event sponsored in part by the National Association for Medical equipment suppliers (NAMES).

The four regional DMERCs joined together and presented a DMERC Update to the suppliers who where in attendance at the Show. The managers of the Professional Relations Units who presented were: Vikki Menichillo, Region A; Susan Joyce, Region B; Elaine Hensley, Region C; and Cynthia York, Region D. Topics discussed were Y2k, documentation for individual consideration; Medicare + choice; and proof of delivery.

This is just one of many anticipated events in which the DMERCs will combine resources to provide superior customer service to our suppliers.

Wilkes-Barre Seminar Presenters

Standing: Paul Komishock, Tom O'Connor, Dave Fiorini
Seated: Suzanne Smetana, Vikki Menichillo

Fall Seminar Changes

Traditionally, the Professional Relations staff at the Region A DMERC has provided supplier training / educational seminars on a bi-annual basis. Spring seminars have usually focused on more generalized issues, while topics addressed in the fall have held a more policy-specific agenda. After careful evaluation, the Fall '99 supplier outreach schedule has been revised.

Moving away from our traditional seminar format, we are currently developing a new program of training / education designed to better serve the needs of the supplier community. Our efforts include education targeting need-specific issues presented in a more individualized manner.

Assuredly, great time and detail will be placed into our planning in order to offer to you an educational program built upon integrity and quality, and most importantly, designed in accordance with HCFA guidelines. Please be alert to more information and updates regarding educational outreach via our internet website, bulletin board, and supplier notices. We are excited about these changes and looking forward to working with you!

Seminar Update

The Professional Relations Unit at the Region A DMERC recently completed a comprehensive round of spring seminars. The focus was on basic billing and advanced billing. We, at Region A, would like to thank all those suppliers who attended for their enthausiatic participation at the seminars!

The following is a list of comments from the evaluations that were completed at the seminars:

- Portland, ME

  Great Job!

  Good pace, orderly presentation, overheads complement workbook.

  Questions were all answered effectively.

- Bedford, NH

  Region A is very cooperative to work with. Thanks

  Presenters did a great job.

  Presentation was more informative regarding specific courses of action following certain problems.

  Seem to move smoothly. Questions allowed were general to help everyone and wasn't just a bashing session.

- East Elmhurst, NY

  Very well presented.

  Improved! Went into detail. Did not leave you hanging!

  Speakers are very helpful and have pleasant personalities.

- East Windsor, NJ

  Always found these seminars to be quite informative.

  Excellent.

  This seminar provided a good starting point – definitely worth attending.

  I found the presenters eager to help and answer questions.

  Presenters were well informed, seemed much more organized.

  Nice job!

  The handouts were better and seminar was better organized.

  Please have more of these seminars with all the latest changes – bring HCFA too!

  This seminar was very knowledgeable, I learned a lot. The presenters were great and explained everything in detail to the best of their knowledge. If they didn't know, they told us where to find or get the answer.

  Very informative. All my questions were answered.

- Hartford, CT

  The three gentlemen were knowledgable in answering all questions; didn't rush through just to get done. Also, very informative.

  Appreciate audience questions being repeated by speaker so all could hear. Pleasant, well-informed presenters.

  Handled themselves very professionally while faced with frustrating and tough questions that were specific to customer service.

- Atlantic City, NJ

  Very informative.

  The structure and presenters were better organized than last year's seminar. The presenters were very articulate and patient, especially in answering questions.

- Buffalo, NY

  Overall, good presentation.

  Very informative session.

  Found morning session very informative and pertinent. Issues that we had questions about were addressed, especially CMN documentation.

- Philadelphia, PA

  Always very helpful.

  Information presented was good. The booklet for "201" was well done with room for notes on each slide. The speakers were informative and obviously know the subjects well.

  Well prepared and clear

- Boston, MA

  Very informative workshop

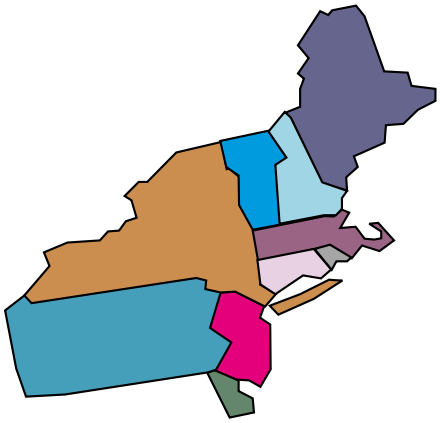
  Better presenters this time

  Better explanation and speakers

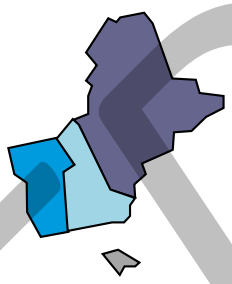
  Professional staff "well done"

Region A DMERC has collected all constructive feedback received and we plan to incorporate supplier suggestions whenever possible to improve our supplier outreach presentations.

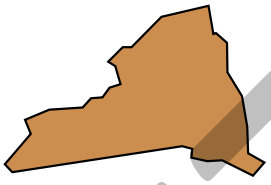
Region A DMERC
Ombudsmen Terriories
570-735-9666



Thomas OConnor
Ombudsman at Large

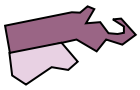


ME, NH, RI, VT
Kevin Quaglia
Area Codes: 207, 401, 603, 802
State Association: NEMED

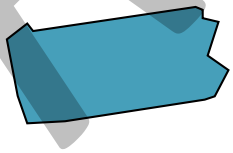


NY State
Suzanne Smetana
Area Codes: 315, 518, 607, 716, 914
State Association: NYMEP

NY City & Long Island
Cheri Cross
Area Codes: 212, 516, 718, 917
State Association: NYMEP



CT, MA
David Fiorini
Area Codes: 203, 413, 508, 617, 781, 860, 978
State Association: NEMED



PA
Brian Kapsick
Area Codes: 215, 267, 412, 484, 570, 610, 717, 724, 814
State Association: PAMS

DE, NJ
Paul Komishock
Area Codes: 201, 302, 609, 732, 908, 973
State Association: JAMES

PRODUCT/PROCESS FOCUS GROUPS
570-735-9666

Mobility

Suzanne Smetana – Ombudsman – Primary
Paul Komishock – Ombudsman – Secondary

Canes/Crutches
Power Operated Vehicle
Repairs/DME
Seat Lift Mechanisms
Seating Systems
Walkers
Wheelchairs

Nutrition/Pharmacy

Brian Kapsick – Ombudsman – Primary
Cheri Cross – Ombudsman – Secondary

Dialysis Equipment/Supplies/EPO
Enteral Nutrition
Immunosuppressive Drugs
Infusion Pumps
Oral Antemetic
Oral Anti-Cancer Drugs
Parenteral Nutrition

Orthotics & Prosthetics

David Fiorini – Ombudsman - Primary
Kevin Quaglia – Ombudsman – Secondary

Diabetic Shoes
Dynamic Splints
Lower/Upper Limb Orthosis
Lower/Upper Limb Prosthesis
Orthotic/Prosthetic Repairs
Orthopedic Footwear
Spinal Orthosis

Respiratory

Kevin Quaglia – Ombudsman – Primary
David Fiorini – Ombudsman – Secondary

CPAP/BIPAP
IPPB
Nebulizers
Oxygen Supplies/Equipment
Suction Pumps
Tracheostomy Supplies
Ventilators

Specialized DME

Paul Komishock – Ombudsman – Primary
Suzanne Smetana – Ombudsman – Secondary

Breast Prosthesis
CPM & Neuromuscular
Diabetic Supplies
DME
Heat/Cold Application & IDE
Impotence Aid
Lymphedema Pumps
Maxillofacial/Misc
Ostomy & Urologicals
Surgical Dressings
TENS & Osteogenic Bone Stimulator
Vision – Lenses & Prosthesis
Voice Prosthesis

Supports

Cheri Cross – Ombudsman – Primary
Brian Kapsick – Ombudsman – Secondary

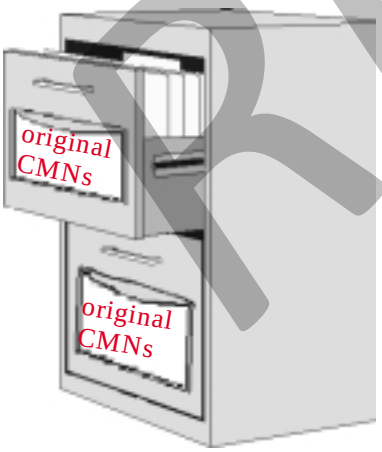
Commodes/Bed Pans/Urinals
Hospital Beds/Accessories
Patient Lifts
Support Surfaces
Traction
Trapeze Bars

Please Note: The Secondary Ombudsman serves as backup/support to the Primary Ombudsman for the product category.

CMNs Original vs. Copy

During recent audits of Certificates of Medical Necessity (CMNs), it was discovered that suppliers are sending in the *original* CMN attached to claims for processing.

Original CMNs are to be retained by the supplier in the beneficiary's file. A *copy* of the CMN is to be sent in with a claim for processing. Original CMNs are to be sent to the DMERC only when they have been specifically requested.



Respiratory Assist Device (RAD) – New Code

For dates of service on or after October 1, 1999, the following HCPCS code has been established:

K0534 Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)

This code describes a bi-level pressure device used with an ***invasive*** interface. This code should be billed only if the bi-level pressure device is being used with an invasive interface. Code E0453 is no longer valid for billing to the DMERC for dates of service on or after October 1, 1999. Code K0534 replaces code E0453 when E0453 is used with an invasive interface.

Accessories used with K0534 will have the same usual maximum amounts as described in the DMERC RAD Regional Medical Review Policy for accessory codes K0187 - K0189 (see the following article entitled "Accessories Used With CPAP Devices").

New Respiratory Assist Devices Policy

A new Respiratory Assist Devices (RAD) DMERC Regional Medical Review Policy (RMRP) is being published with this issue of *DMERC Medicare News*. Its effective date of implementation is for dates of service on or after October 1, 1999.

The Health Care Financing Administration (HCFA) has proposed that the policy on Respiratory Assist Devices be effective October 1, 1999. Before implementing this policy, however, there will be an open meeting in the near future at HCFA in Baltimore to discuss the appropriate DME payment category for respiratory assist devices with bi-level pressure capability and with the backup rate feature. Please watch for the Federal Register notice of the meeting. HCFA hopes that all interested parties, including the physician community, the supplier community, and beneficiaries will be in attendance and that there will be a full discussion of the issue of the assignment of these devices into the capped rental payment category. It is HCFA's view that these devices are excluded from the class for items requiring frequent and substantial servicing in accordance with section 1834(a)(3) of the Social Security Act. HCFA will be accepting written comments on the appropriateness of the DME payment category for respiratory assist devices with bi-level pressure capability and with the backup rate feature that are received no later than 5 p.m. on June 15, 1999. Comments should be mailed to the following address:

Health Care Financing Administration
Division of Community Post-Acute Care
Attn: Joel Kaiser
C5-06-27
7500 Security Boulevard
Baltimore, MD 21244-1850

Comments may also be submitted electronically to the following e-mail address:

jkaiser@hcfa.gov

E-mail comments must include the full name, address, and affiliation (if applicable) of the sender, and must be submitted to the referenced address in order to be considered. All comments must be incorporated in the e-mail message because we may not be able to access attachments.

A special DMERC bulletin will be issued some time after the public meeting and prior to October 1, 1999, and will contain the determination of the payment category for each code and all applicable billing instructions.

Accessories Used With CPAP Devices

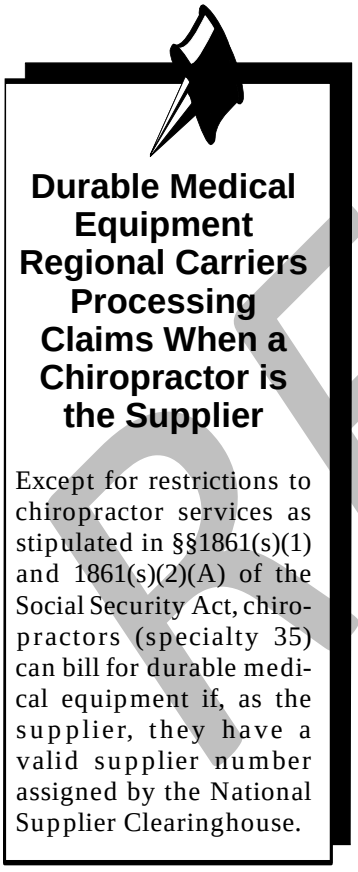
The Respiratory Assist Devices Regional Medical Review Policy describes usual maximum amounts of accessories (K0183-K0189) used with respiratory assist devices K0532 and K0533 which are expected to be medically necessary within a period of time (see below). Since these codes represent the same accessories used with a CPAP device (E0601), for dates of service on or after October 1,1999, the published amounts for these accessories will apply to their use with CPAP devices as well.

Accessories:

The following table represents the usual maximum amount of accessories expected to be medically necessary:

K0183	1 per 3 months
K0184	2 per 1 month
K0185	1 per 6 months
K0186	1 per 6 months
K0187	1 per 1 month
K0188	2 per 1 month
K0189	1 per 6 months

Claims for more than the usual maximum replacement amount will be denied as not medically necessary unless the claim is accompanied by documentation which justifies a larger quantity in the individual case.



Durable Medical Equipment Regional Carriers Processing Claims When a Chiropractor is the Supplier

Except for restrictions to chiropractor services as stipulated in §§1861(s)(1) and 1861(s)(2)(A) of the Social Security Act, chiropractors (specialty 35) can bill for durable medical equipment if, as the supplier, they have a valid supplier number assigned by the National Supplier Clearinghouse.

AFO/KAFO/Ankle Positioning Splint – Policy Revision

A revision of the Ankle-Foot and Knee-Ankle-Foot Orthoses policy is included in the accompanying *Supplier Manual* update. The basic elements of the current AFO/KAFO policy have not changed. Some of the changes include:

- Adding codes for all additions to AFOs to the HCPCS section for completeness,
- Adding definitions for prefabricated and custom fabricated orthoses,
- Adding definitions and coding guidelines distinguishing AFOs from foot orthotics,
- Distinguishing AFOs used in ambulatory patients from those used in nonambulatory patients for coding and coverage purposes,
- Placing Coverage and Payment information from the current AFO/KAFO policy in a subsection titled "AFOs and KAFOs used in ambulatory patients,"
- Adding a statement that socks used in conjunction with orthoses are noncovered (effective for dates of service on or after 10/1/99),
- Specifying codes for custom fabricated orthoses in the Coding Guidelines section,
- Incorporating information that had been previously published about code L2860 into the Coding Guidelines section,
- Adding statements to the Documentation section about using the ZY modifier when billing for noncovered uses of AFOs (effective for dates of service on or after 10/1/99).

The revised policy incorporates and updates all the information from the current policy on Ankle Positioning Splints. Therefore, the Ankle Positioning Splint policy as a separate policy will be deleted when the revised AFO/KAFO policy becomes effective (i.e., dates of service on or

after 10/1/99). Some of the changes relating to ankle positioning splints include:

- Updating the HCPCS codes because all of the codes in the current Ankle Positioning Splint policy have either been previously converted to L codes or eliminated,
- Clarifying definitions and coverage statements relating to ankle positioning splints,
- Placing Coverage and Payment information from the current Ankle Positioning Splint policy in a subsection titled "AFOs used in nonambulatory patients,"
- Adding statements to the Documentation section about using the ZY modifier when billing for noncovered uses of AFOs (effective for dates of service on or after 10/1/99).

Immunosuppressive Drugs Following Pancreas Transplant

As the result of a revision to the *Medicare Coverage Issues Manual*, Section 35-82, coverage of immunosuppressive drugs is being extended to include patients who meet all of the following criteria:

- The patient receives a Medicare-covered whole organ pancreas transplant on or after July 1, 1999, and
- The patient has had a prior Medicare-covered kidney transplant because of diabetic nephropathy, and
- The patient was enrolled in Medicare Part A at the time of both transplants and is enrolled in Medicare Part B at the time that the drugs are dispensed, and
- The drugs are medically necessary to prevent or treat rejection of the organ transplants in the particular patient, and
- The drugs are furnished within 36 months after discharge from the hospital following the pancreas transplant.

Immunosuppressive drugs will be denied as noncovered if they are used following a whole organ pancreas transplant that was not simultaneous with or preceded by a kidney transplant for diabetic nephropathy. Coverage of immunosuppressive drugs already exists and will continue for patients who have had a pancreas transplant simultaneous with a Medicare-covered kidney transplant because in these situations coverage is based on the kidney transplant. Because Medicare does not cover transplantation of partial pancreatic tissue or islet cells, if these tissues are transplanted subsequent to a Medicare- covered kidney transplant, coverage of immunosuppressive drugs will be limited to those furnished within 36 months after hospital discharge following the kidney transplant.

Refer to the Immunosuppressive Drugs policy in the *Region A DMERC Supplier Manual* for more information on Coverage and Payment Rules, Coding Guidelines, and Documentation requirements. On the DMERC Information Form (DIF), in question # 5 which asks for the organ that has been transplanted most recently, enter the statement "whole organ pancreas transplant subsequent to Medicare-covered kidney transplant" if this correctly describes the patient's situation. Because of Y2K systems issues, until further notice, initial claims for immuno- suppressive drugs related to a pancreas transplant subsequent to a kidney transplant must be filed hard copy. Subsequent claims in these situations may be filed electronically.

Portable Oxygen

Effective for claims with dates of service on or after October 1, 1999, if the certification for home oxygen is based on an oxygen test obtained during sleep and if all coverage criteria are met, Medicare will only cover a stationary oxygen system. Portable oxygen systems provided for patients whose certification is based on an oxygen test obtained during sleep will be denied as not medically necessary

External Infusion Pump Policy Updated

The Regional Medical Review Policy on External Infusion Pumps has been updated, incorporating the following changes:

- General "Reasonable and Necessary" criteria were added to the beginning of the "Coverage and Payment Rules" section.

- The first part of "Coverage and Payment Rules" was reformatted to improve readability. Changes in the numbering scheme and the addition of bullets and references in the text are intended to improve clarity and interpretation of eligibility criteria.
- Coverage of liposomal amphotericin B (J0286) was added. This code became effective January 1, 1999 and is covered for patients who have had significant toxicity to standard amphotericin and are unable to complete that course of therapy or for those patients who have significantly impaired hepatic function.

Indication for use of epoprostenol (Flolan®) (Code J1325). Effective for dates of service on or after February 1, 1999, J1325 will be covered for those patients with pulmonary hypertension secondary to a connective tissue disease.

Heated Humidifier – New Code

A new code has been established for a heated humidifier that is used with a CPAP device (E0601) or a respiratory assist device (K0532, K0533, or K0534):

K0531 Humidifier, heated, used with positive airway pressure device

This code is effective for dates of service on or after October 1, 1999. Code K0531 is in the Inexpensive or Routinely Purchased (IRP) DME payment category.

Published clinical evidence has not demonstrated that a heated humidifier provides a significant benefit compared to a nonheated humidifier. Therefore, if a K0531 humidifier is provided for use with a covered CPAP device or a covered respiratory assist device, payment will be based on the allowance for the least costly medically appropriate alternative, K0268 (nonheated humidifier). This is a continuation of current DMERC policy.

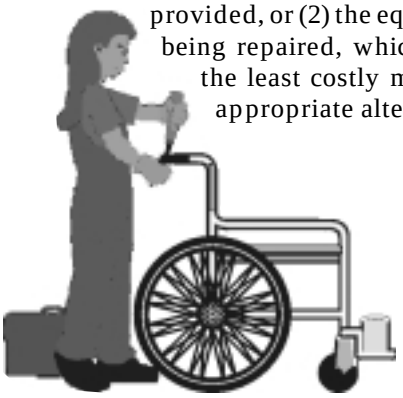
Temporary Replacement Equipment – Documentation Requirement

Code K0462 (temporary replacement for patient owned equipment being repaired, any type) should be used to bill for the temporary replacement of patient-owned equipment, such as a wheelchair, which is being repaired. Coverage consideration will be given if the patient-owned equipment is covered by Medicare and will not be available for use for more than one day (e.g., if the repair took over 1 day).

Effective dates of service on or after July 1, 1999 a claim for code K0462 representing replacement equipment must include:

- Narrative description, manufacturer, and brand name / number of the equipment being repaired, and
- Date of purchase of the equipment being repaired, and
- Narrative description, manufacturer, and brand name / number of the equipment provided as a temporary replacement, and
- Description of what was repaired, and
- Explanation of why the repair took longer than one day.

If this information is not included, the claim will be denied as not medically necessary. If coverage is approved for the replacement equipment, up to one month's rental will be reimbursed at the level of either (1) the equipment provided, or (2) the equipment being repaired, whichever is the least costly medically appropriate alternative.



Oral Anti-Emetic Drugs

Effective for dates of service on or after January 1, 1999, the DMERCs began processing claims for oral anti-emetic drugs when they are used in conjunction with intravenous cancer chemotherapeutic regimens and are dispensed by a pharmacy. (If these drugs are dispensed by the ordering physician, they must be billed to the local carrier. If they are dispensed in an outpatient hospital facility, they must be billed to the local intermediary.) Special Q codes (Q0163-Q0181) have been established to bill for these drugs in these situations. The codes are:

Q0163 Diphenhydramine hydrochloride 50mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen

Q0164 Prochlorperazine maleate 5mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0165 Prochlorperazine maleate 10mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0166 Granisetron hydrochloride 1mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen

Q0167 Dronabinol 2.5mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0168 Dronabinol 5mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0169 Promethazine hydrochloride 12.5mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0170 Promethazine hydrochloride 25mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0171 Chlorpromazine hydrochloride 10mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0172 Chlorpromazine hydrochloride 25mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0173 Trimethobenzamide hydrochloride 250mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0174 Thiethylperazine maleate 10mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0175 Perphenazine 4mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0176 Perphenazine 8mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hours dosage regimen

Q0177 Hydroxyzine pamoate 25mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0178 Hydroxyzine pamoate 50mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treat-

ment, not to exceed a 48 hour dosage regimen

Q0179 Ondansetron hydrochloride 8mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Q0180 Dolasetron mesylate 100mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen

Q0181 Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen

Oral anti-emetic drugs billed with codes Q0163-Q0181 are covered only if all of the following criteria are met:

1. The drug has been approved by the Food and Drug Administration (FDA) for use as an anti-emetic, and

2. The drug has been ordered by the treating physician as part of a cancer chemotherapy regimen, and

3. The drug is used as a full therapeutic replacement for an intravenous anti-emetic drug that would otherwise have been administered at the time of the chemotherapy treatment, and

4. The initial dose of the oral anti-emetic drug is administered within 2 hours of the administration of the chemotherapy drug.

If all of the above criteria are met, the quantity of oral anti-emetic drugs covered for each episode of chemotherapy cannot exceed the initial loading dose plus 48 hours of therapy. However, for the drugs granisetron (Q0166) and dolasetron (Q0180), the quantity of drugs covered for each episode of chemotherapy is limited to the initial loading dose plus 24 hours of therapy.

Criterion 3 is not met when the chemotherapy drug is an oral drug or when the chemotherapy drug is administered intravenously in the home setting because the type and dosage of chemotherapy drugs administered in these situations do not require intravenous anti-emetic drugs.

Oral anti-emetic drugs which do not meet all of the criteria described above are noncovered under section 1861(s)(2)(T) of the Social Security Act.

The supplier may bill for only a single course of oral anti-emetic drugs at a time and the quantity of drugs billed using codes Q0163-Q0181 must not exceed the 24 or 48 hours of therapy specified above.

The supplier must have a detailed written order for the drug which has been signed and dated by the treating physician. There must be a statement on the order which indicates that the oral anti-emetic drug is a full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapy regimen. The patient's cancer diagnosis must be entered on the order by the physician. This order must be available to the DMERC on request. The supplier may bill using code Q0163-Q0181 only if they have a written order with the specified attestation. The supplier must enter an ICD-9 diagnosis code corresponding to the patient's cancer diagnosis on each claim.

Code Q0181 is miscellaneous code which may be used only when all the requirements of the policy are met, but the drug administered does not have a specific code (Q0163-Q0180). Claims for code Q0181 must be accompanied by the name of the drug, the dosage strength dispensed, the number of tablets and frequency of administration during the covered time period (24-48 hours) as specified on the order. This information should be entered in the HA0 record of an electronic claim or attached to a hard copy claim.

The coverage of oral anti-emetic drugs described above (i.e., as a full therapeutic substitute for an intravenous anti-emetic at the time of chemotherapy treatment) and billed using codes Q0163-Q0181 is distinct from coverage of oral anti-emetic drugs (billed using code K0415) which are related to the administration of oral anti-cancer drugs. For information on coverage of drugs under the latter benefit, refer to *DMERC Region A Supplier Manual,* and the *Region A DMERC Newsletter*, April 1996.

Home Blood Glucose Monitors

The Region A DMERC erroneously published the wrong version of the Home Blood Glucose Monitor Policy in our last bulletin. The version that was published did not contain revisions to the documentation section that were made after the comment period. The correct version is contained in the *Supplier Manual* Update section of this bulletin. Please remove the previous version of you policy and replace it with the current one.

We regret any inconvenience or confusion that this error may have caused. Please note Supplier Notice 99-08, found on page 17 of this issue.

Certificates of Medical Necessity and Orders

HCFA has recently provided guidance to the DMERCs regarding Certificates of Medical Necessity and physician orders. The purpose of this bulletin article is to review these guidelines with suppliers regarding these items.

No. 1 Cover Letters for Certificates of Medical Necessity

Cover letters may be used by a supplier as a mechanism to communicate with the physician.

Suppliers should remind physicians of their responsibility to properly and conscientiously complete the Certificate of Medical Necessity for those items they have prescribed for their patients. It is the physician's duty to determine and document the medical need and utilization for items that are billed to Medicare. The physician should ensure that information relating to the beneficiaries medical condition is correct. Suppliers may use cover letters to remind the physician of these responsibilities.

Physician should complete Section B accurately and clearly and assure that adequate notation is made into the patient's chart corroborating the answers supplied in Section B of the Certificate of Medical Necessity. Audits performed by the DMERC may require copies of relevant portions of the patient's chart to ultimately establish the existence of the medical need as represented on the Certificate of Medical Necessity that was submitted with the claim.

Suppliers are encouraged to provide physicians with information regarding the Coverage and Payment Criteria of any given policy. Accompanying this bulletin article is an article that suppliers may reproduce as an educational tool for physicians.

No. 2 Certificates of Medical Necessity and Physician Orders

The following is an outline of documentation requirements that must be followed for claim submission. Claims which do not meet these documentation requirements will be denied and / or an overpayment assessed.

- A written order must be sufficiently detailed and include: (1) the patient's name; (2) description of the item (the description can be either a narrative or a brand name / model number); (3) physician's signature; and (4) all options or additional features which will be separately billed or which will require an upgraded code.
- The date on the written order or the CMN should be the date that the physician has signed the written order and / or CMN.
- A supplier must have a verbal, faxed, or original order in their records before they provide any item of durable medical equipment, prosthetics, orthotics and supplies to a beneficiary.
- For items that are dispensed based on a verbal order, the written order must clearly specify the start date of the order. If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need.
- A new written order and a new CMN are required when there is a change in equipment.
- For items that are recurring in nature, a new order and a new CMN is required if the beneficiary changes suppliers.
- A supplier must have a faxed or original signed order and a faxed or original CMN (when applicable) in their records before they can submit a claim for payment to Medicare.
- The DMERCs have the authority to request to see the original order or a CMN at any time. If the original order or CMN is not available either at the suppliers or in the patient's medical record maintained by the ordering physician, or that the faxed CMN has been altered, the DMERCs should consider the service not reasonable and necessary and initiate a denial or an overpayment action.
- A supplier is required to obtain a signed order from a physician before delivery of certain types of durable medical equipment. Items that require a written order prior to delivery are decubitus care items, seat lift mechanisms, transcutaneous electric nerve stimulator, and power operated vehicle.
- If there is any change made to the CMN after the physician has completed section B and signed the CMN, the physician must line through the correction, sign the correction in full, and date the change or the supplier may choose to have the physician complete a new CMN.

From the Region A DMERC Medical Director…

HCFA Issues New Guidance on Certificates of Medical Necessity (CMNs) A Message to Physicians

The Health Care Financing Administration (HCFA) recently issued new guidance on several issues related to CMNs for items reimbursed by Medicare. As you are aware, certain items of durable medical equipment (DME) require additional documentation of medical necessity in the form of a CMN. In the past, you were required to complete Section B of an original, double-sided CMN and after signing and dating the form, return it to the supplier in the mail. Because suppliers were required to have in their possession this original CMN prior to filing a claim to Medicare, delays by physicians in returning this form often resulted in delays in reimbursement to the supplier. CMNs sent via fax were not a valid form of documentation for submission of claims.

HCFA, in their new guidance effective May 1, 1999, has approved the facsimile transmission of completed CMNs by physicians to the supplier. HCFA hopes that by allowing the faxing of this document between a physician and supplier, the supplier will receive CMNs in a more timely fashion in order to file their Medicare claims. In addition, HCFA has stated that the signed and dated CMN with the physician's original signature may be kept on file either with the supplier or in the ordering physician's medical record for the patient. *Since the DMERC must be able to verify original signatures, it is critical that this CMN, with your original signature and date, be maintained in your records should you choose not to send it back to the supplier. The faxed copy sent to the supplier does not contain an original signature. In the event of an audit by Medicare, the supplier must be able to furnish this original document or risk denial of the claim and assessment of an overpayment.*

What does this mean to you? Fewer hassles with Medicare paperwork. Faster, more efficient provision of DME items to your patient. Improved cashflow for the suppliers working in partnership with you to provide for your patient's medical needs.

In this same HCFA notification, two other topics were addressed that relate to CMNs. As you know, suppliers often use a cover letter with CMNs to communicate with the ordering physician. This cover letter often contains information about what you or your staff has ordered from the supplier for your patient, sometimes referred to as a "written confirmation of verbal order." HCFA has taken the position that the cover letter is not part of the CMN; therefore, they can not regulate or restrict the information included in this communication. *However, it remains HCFA and the DMERCs position that you, the physician, are responsible for documenting both the medical necessity and the utilization of all health care services for Medicare beneficiaries, including DME, prostheses, orthoses and supplies.* All answers provided in Section B, whether completed by you or your staff member, must be supported by information contained in your patient's medical records. The DMERC, in the event of an audit, will request copies of your patient's medical records to verify that the medical necessity information provided in Section B is accurate and meets Medicare coverage criteria for the item(s) in question. Your knowledge of Medicare guidelines and active involvement in providing or confirming medical necessity information is crucial to the integrity of the Medicare program.

The second topic addresses procedures for changes to a completed CMN. We are aware that mistakes can be made by you or your staff in the completion of Section B of the CMN. However, there are also situations where a supplier may change your answers after you complete the CMN and return it to the supplier. This fraudulent activity by the supplier could result in items being provided that were not medically necessary and, quite possibly, could result in harm to your patient. Similar to correction of errors made in hospital or medical notes, HCFA is now requiring that you strike through the error, make the necessary corrections then sign in full and date the correction(s). This date should correspond to the date that the correction(s) was made. Suppliers also have the option of requesting the completion of a new CMN. Hopefully, this change in policy will protect you, your staff and your patients from unscrupulous suppliers intent on defrauding the Medicare program. *Please remember* - The supplier is still prohibited from completing Section B of the CMN. Should you become aware that a supplier is altering your answers in Section B or providing you with CMNs with Section B already completed, please notify the Region A DMERC Provider Services Unit at 570-735-9445.

Supplier Notices

The information contained in the Supplier Notices was accurate at the time of original publication. Some of the contents may have since been updated or changed.

1999 Fees

Supplier Notice 99-07
March 24, 1999

The following tables represent the 1999 Prevailing Charge Information for Enteral and Parenteral Nutrition.

Enteral Nutrition

HCPCS	75th	50th	IIC	LCL
B4034	7.17	6.31	5.60	6.00
B4035	14.83	14.17	10.67	11.50
B4036	8.33	8.33	7.31	8.06
B4081	27.51	23.33	19.78	21.08
B4082	20.00	16.38	14.73	16.20
B4083	4.00	2.60	2.25	2.50
B4084	21.20	19.00	17.03	16.52
B4085	51.06	45.00	37.48	0.00
B4150	0.85	0.72	0.61	0.67
B4151	1.87	1.63	1.43	1.52
B4152	0.72	0.59	0.51	0.55
B4153	2.50	2.02	1.74	1.90
B4154	1.12	1.12	1.12	0.00
B4155	.89	.89	.89	0.00
B4156	2.09	1.50	1.24	1.32
B9000NU	1121.97	1121.97	1121.97	0.00
B9000UE	841.47	841.47	841.47	0.00
B9000MS	51.55	51.55	51.55	51.55
B9000RR	150.00	120.00	103.10	108.00
B9002NU	1247.00	1247.00	1121.97	0.00
B9002UE	841.47	841.47	841.47	0.00
B9002MS	54.33	54.33	54.33	54.33
B9002RR	132.00	121.28	108.66	115.80
E0776RRXA	39.20	30.38	23.62	25.15
E0776NUXA	108.15	99.00	99.00	93.30
E0776UEXA	81.11	74.25	74.25	75.25

Parenteral Nutrition

HCPCS	75TH	50TH	IIC	LCL
B4164	44.82	35.40	15.08	35.40
B4168	21.96	21.96	21.96	0.00
B4172	*IC	*IC	*IC	*IC
B4176	89.00	77.00	38.94	76.50
B4178	51.04	51.04	51.04	51.04
B4180	21.61	21.61	21.61	0.00
B4184	124.67	106.50	70.86	76.77
B4186	186.40	168.00	94.48	100.00
B4189	277.68	211.06	157.66	195.98
B4193	390.83	309.25	203.73	230.00
B4197	394.28	377.00	248.02	262.10
B4199	478.48	414.45	298.43	283.42
B4216	47.14	47.14	6.85	13.04
B4220	18.04	11.97	7.10	8.87
B4222	16.94	15.57	8.02	12.61
B4224	32.84	32.84	22.19	26.54
B5000	12.50	12.50	10.54	11.53
B5100	8.50	5.05	4.12	4.93
B5200	0.00	0.00	5.68	0.00
B9004RR	500.00	500.00	354.30	429.56
B9004NU	2238.01	2238.01	2238.01	0.00
B9004UE	1678.51	1678.51	1678.51	0.00
B9004MS	177.15	177.15	177.15	177.15
B9006RR	510.00	435.00	354.30	374.40
B9006NU	2238.01	2238.01	2238.01	0.00
B9006UE	1678.51	1678.51	1678.51	0.00
B9006MS	177.15	177.15	177.15	177.15
B9999	*IC	*IC	*IC	*IC

Notes

75th = Prevailing Charge
50th = Customary Charge
IIC = National Inflation Index Charge
LCL = Lowest Charge Level Prevailing
*IC = Individually Considered

Note: The fees listed may not reflect the supplier's actual allowances for an item. Medicare calculates the allowance for each procedure code listed above by selecting the lowest of the following: the Prevailing Charge, the Lowest Charge Level Prevailing, the supplier's Customary Charge, the Inflation Index Charge, or the Actual Charge.

Correction to Home Blood Glucose Monitor Policy Revision

Supplier Notice 99-08
March 31, 1999

The Home Blood Glucose Monitor Policy that was included in Supplier Manual Revision #9, dated March 1999, was not the updated version. The updated version will be included with the June Supplier Manual Policy Revision.

There are two changes to the policy. They are as follows:

Coverage and Payment Rules

For any item to be covered by Medicare, it must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The determination of medical necessity for the items addressed by this policy will be based on the information contained in this section.

The above paragraph was not present in the previous policy version. The second change refers to section F. The section should read:

f) If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g. a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g. a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every 6 months.

It is important to note that the supplier is NO LONGER REQUIRED to keep a testing log on file. However, keeping a log will still satisfy the documentation requirement.

We apologize for any inconvenience this may have caused.

Quick Reference Guide for Customer Service and Professional Relations

Supplier Notice 99-09
April 2, 1999

Please be aware a new telephone message will be heard when dialing the Professional Relations Department. The message will be:

"You have reached the Professional Relations Department of United HealthCare / Medicare the DMERC Region A. In an effort to respond to all calls in a timely manner, calls are being transferred to the Customer Service Unit. Issues regarding Ombudsman assistance will be forwarded to the appropriate Ombudsman to address. You may contact the Customer Service Unit directly by calling (570) 735-9445."

To help assist you in "who should you contact," here is a quick reference guide:

First contact for your questions: ARU/VPIQ for claim inquiry/status

Customer Service
Monday through Friday 8:00 AM – 4:00 PM (570) 735-9445
Contact Customer Service Representatives for:
- Coverage Issues
- General Policy Coverage Information
- General DMERC Information

Professional Relations
Monday through Friday 8:00 AM – 4:00 PM
Ombudsman Category / Territory Defines Contact

- Educational Seminars / Workshops / Issues
- Trade Shows
- Association Meetings
- Issues Affecting Multiple Suppliers
- Broad Product Related Issues

Breakdown of Calories

Supplier Notice 99-10
April 22, 1999

Questions #10 and 11 of the Enteral CMN 10.02B should include the name of the product being provided and a breakdown of calories per day for each product.

When more than one product is listed in question 10, there should be a breakdown of calories for each of these products and this information should be listed in question 11.

Claims received by the DMERC where the CMN does not include the breakdown of calories by product *will be denied.*

Thank you for your prompt attention to this matter.

CMN Reject Report

Supplier Notice 99-11
May 7, 1999

Effective May 17, 1999, the CMN Reject Report will be available to download from the Bulletin Board System. The menu option for downloading will be the letter O. The Region A DMERC will continue to mail out this report to submitters until July 6, 1999; after this date the submitter will be responsible for downloading the report. Under NO circumstances will this be mailed after July 6, 1999.

Thank you for your attention to this matter.

Revision to Fee Schedule

Supplier Notice 99-12
May 24, 1999

Periodically, the allowable amounts for DME items are reviewed. During the first quarter of 1999, the allowable for procedure code for the following code has been changed:

E0147- Heavy duty, multiple braking system, variable wheel resistance walker. The amount allowed for this code is now $548.27, for all of Region A.

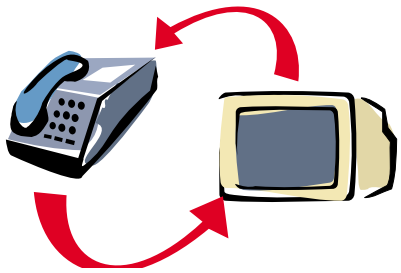
Please note that the fee on our website will not be updated until the fee schedule is republished.

EDI

Attention: EDI Submitters

The Bulletin Board System is available for transmission of claims 7 days a week with the following exceptions:

- 12 midnight to approximately 6 AM (this time may vary due to maintenance needs)
- 7AM to approximately 8 AM
- 1 PM to approximately 2 PM
- 6 PM to approximately 6:30 PM



Modifiers Reminder

This is an *important reminder* with examples of the proper use of HCPCS modifiers when billing for wheelchairs and wheelchair accessories/options.

For assigned claims, if the modifier is missing or invalid the claim will be denied as unprocessable in accordance with HCFA return/reject mandate. For non-assigned claims where modifier is missing or invalid, the claims will be denied because the information was missing or incorrect. This will affect all claims received on or after October 1, 1998.

In addition, claims will be denied under the return/reject mandate when unnecessary modifiers are used. Claims that are denied must be resubmitted with complete valid information for appropriate claim adjudication. Please make note of this information to avoid any unnecessary claim denials.

Wheelchair Base Related Modifier Table

CAPPED RENTALS	*MONTHS*	*MODIFIERS*
K0001 – K0004 K0006 – K0007	1	RRKH
	2 – 3	RRKI
	4 – 10	RRKJ
	11 – 15	RRKJ (BP, BR, or BU)
K0010 – K0012 K0014	1	RRKH (BP, BR, or BU) or NUKH (BP, BR, or BU)
	2 – 3	RRKI
	4 – 10	RRKJ
	11 – 15	RRKJ (BP, BR, or BU)

INEXPENSIVE & ROUTINELY PURCHASED EQUIPMENT	*MONTHS*	*MODIFIERS*
K0005	RENTED UP TO PURCHASE PRICE (1-10)	RR
	PURCHASED NEW	NU
	PURCHASED USED	UE

CUSTOM ITEMS	*MONTHS*	*MODIFIERS*
K0008, K0013	PURCHASED NEW ONLY	NU
K0009	PURCHASE or RENTAL	RR or NU

LOANER CODE	*MONTHS*	*MODIFIERS*
K0462		NO MODIFIER REQUIRED

Wheelchair Accessories Related Modifier Table

CAPPED RENTALS	*MONTHS*	*MODIFIERS*
K0195, K0101	1	RRKH
	2 – 3	RRKI
	4 – 10	RRKJ
	11 – 15	RRKJ (BP, BR, or BU)

INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT	*MONTHS*	*MODIFIERS*
K0020, L3964-L3966, L3968-L3970, L3972, L3974, K0022-K0028, K0114-K0116, E0192, E0962-E0965, K0029-K0033, K0054-K0058, K0065, K0079-K0080, K0088-K0089, K0098, K0102-K0105, K0107, K0452	RENTED UP TO PURCHASE PRICE (1 – 10)	RR
	PURCHASED NEW	NU
	PURCHASED USED	UE

INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT WITH A RIGHT OR LEFT OPTION	*MONTHS*	*MODIFIERS*
K0015-K0019, K0021, K0034-K0053, K0059-K0064, K0066-K0078, K0081-K0087, K0090-K0097, K0099-K0101, K0106	RENTED UP TO PURCHASED PRICE (1-10)	RRLT or RRRT, or RRLTRT(When 2 units are billed)
	PURCHASED NEW	NULT or NURT or NULTRT (When 2 units are billed)
	PURCHASED USED	UELT or UERT or UELTRT (When 2 units are billed)

CAPPED RENTALS WITH THE RIGHT OR LEFT OPTION	*MONTHS*	*MODIFIERS*
K0101	1	RRKHLT or RRKHRT
	2 –3	RRKILT or RRKIRT
	11 – 15	RRKJLT (BP, BR, or BU) or RRKJRT(BP, BR, or BU)

OTHER ACCESSORIES	*MONTHS*	*MODIFIERS*
K0108	RENTED UP TO PURCHASE PRICE	RR (RT and/or LT when appropriate)
	PURCHASED NEW	NU (RT and/or LT when appropriate)

SADMERC Helpline

HCPCS Helpline (SADMERC)

Effective May 1, 1999, the HCPCS Helpline Representatives at the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) will be available to answer your coding questions from 9:00 a.m. – 4:00 p.m. EST Monday through Friday, with extended hours on Wednesday. The helpline will remain open until 6:00 p.m. EST on Wednesday. Also note that the helpline remains open throughout the lunch hour. Based on comments from their customer survey, SADMERC determined that extended hours were needed to accommodate their West Coast customers. The SADMERC is always looking for ways to improve service to their customers. If you have suggestions, please feel free to contact the SADMERC through their Website at **http://www.pgba.com/palmetto/main.nsf/allframesets/pro_sadm.html** or by calling the helpline at the number below, or in writing at the address below. In addition to assisting with proper code recommendations, the representatives are able to address fee schedule requests. Unfortunately, they are not able to assist customers with allowables for items not on a fee schedule (e.g., reasonable charge, individually considered).

Questions and inquiries regarding HCPCS code usage and allowables for items on a fee schedule should be directed to:

HCPCS Helpline (803) 736-6809
or
SADMERC / HCPCS Unit
P.O. Box 100143
Columbia, South Carolina 29202-3143

Get Hooked on the Web

The SADMERC strives to stay on the cutting edge of technology. Their latest effort to better serve their customers is their website. If you're connected, it's easy to access up-to-date SADMERC information. Located on the SADMERC Website are all HCPCS advisory articles that are available through the DMERC bulletins and specialty publications, such as the "Required Documentation List for Coding Verification Review." Also located on the SADMERC Website is a copy of all product classification lists, frequently asked question, and any pertinent related links such as the HCFA Fee Schedule for HCPCS Codes. The site also has the ability for you to give the SADMERC feedback. They want to know what you think of their site and any additional information you would like to see. To provide feedback, just click on the feedback button located on all screens. Please remember that the SADMERC cannot address coverage or any claims information. These questions are directed to your DMERC. The website strives to better serve customers by giving them 24-hour access to HCPCS information. The address on the Internet is:

http//www.pgba.com/palmetto/main.nsf/allframesets/pro_sadm.html

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