DMERC

Medicare

News

DMERC Region A Service Office ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800 ◆ Phone (570) 735-9445 ◆ www.umd.nycpic.com
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Region A DMERC Spring 2001 Seminars and Workshops

Mark your calendars – the Spring 2001 seminar and workshop schedules are set!

Seminars:

Region A will hold DMERC 101 seminars to cover the basic billing information that new suppliers and new office staff will need to understand in order to submit claims to the DMERC. Topics to be covered in DMERC 101 are: HCFA-1500 Form, Certificates of Medical Necessity (CMNs), Fraud and Abuse, and Electronic Billing.

Workshops:

The DMERC will also hold mobility and parenteral/enteral nutrition workshops. Both workshops will include a brief overview of the category, a review of the medical policy, a DMERC update and EDI information. These workshops will be held concurrently.

For more information, visit our web site at www.umd.nycpic.com.

Mobility and Parenteral/Enteral Workshops

Dates	Locations	Phone Numbers	Registration Deadlines
February 20, 2001	Holiday Inn by the Bay 88 Spring Street Portland, ME	800-345-5050	February 13, 2001
February 22, 2001	LaGuardia Marriott 102-05 Ditmars Blvd. East Elmhurst, NY	718-565-8900	February 15, 2001
February 27, 2001	Valley Forge Hilton 251 W. DeKalb Pike King of Prussia, PA	610-337-1200	February 20, 2001
March 1, 2001	Adams Mark Hotel 120 Church St. Buffalo, NY	716-845-5100	February 22, 2001

DMERC 101 Seminars:

Dates	Locations	Registration Deadlines
March 1, 2001	The Screening Room Century Plaza 3131 Sheridan Dr. Buffalo, NY	February 22, 2001
March 7, 2001	Upstate Medicare Division 33 Lewis Rd Binghamton, NY	February 28, 2001

To register, complete a registration form on page 3 for each attendee. Registrations are <u>not</u> accepted by telephone.

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Region A DMERC Contacts

HealthNow DMERC A	570-735-9400	Hearings Voice Mail	570-735-9513
HealthNow DMERC A Fax	570-735-9402	Medicare Secondary Payer	570-740-9001
Accounting	570-740-9002	National Supplier Clearinghouse	866-238-9652*
Accounting/MSP Fax	570-735-9594	Professional Relations	570-735-9666
Beneficiary Help Line	570-735-7383	Professional Relations Fax	570-735-9442
Beneficiary Toll Free Help Line	800-842-2052	Reconsiderations Fax	570-735-9599
EDI Fax	570-735-9510	SADMERC	877-735-1326*
EDI Help Desk	570-735-9429	Supplier Help Line	570-735-9445
Hearings Fax	570-735-9599 *(new)*	***** *New toll-free numbers*	

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
The bulletins are available at no cost from our website at www.umd.nycpic.com.

The DMERC reserves the right to cancel any seminar or workshop. If this occurs, attendees who have received confirmations will be notified by telephone. Please do not contact the meeting facility for seminar information; contact the Region A DMERC at 570-735-9406.

Parking Information

Please telephone the workshop facility for specific information regarding location and possible parking fees. Free parking is available for both DMERC 101 Seminar locations.

How to Register

Complete a registration form below for each attendee and mail or fax the registration to the DMERC as noted below.

Mail:
HealthNow DMERC A
P.O. Box 6800
Wilkes-Barre, PA 18773-6800
Attn: Seminar Registration

Fax:
570-735-9442
Attn: Seminar Registration

All attendees must be pre-registered. Due to limited space, registration is on a first come, first served basis. In the event that a particular seminar is filled to capacity, you will be notified by telephone.

Note: If you do not receive your confirmation within 5 days of the event you have registered for, please call our Professional Relations Unit at 570-735-9406. ⌘

Complete a registration form for each person attending. Please type or print clearly.

Company: _____

Supplier Number: _____

Address _____

_____

Phone: _____

Fax: _____

Date of Seminar: _____

Event (circle one): Mobility Parenteral/Enteral DMERC 101

Name of Attendee:_____

Contact Name: _____

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The bulletins are available at no cost from our website at www.umd.nycpic.com.

Billing

Home Health Prospective Payment System (PPS)

All changes described below are effective for home health claims with dates on or after October 1, 2000.

Background Information – PPS Consolidated Billing

The Balanced Budget Act of 1997 required consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services will be made to a single home health agency (HHA) overseeing that plan.

The law states that payment will be made to the primary HHA whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements existed with the primary agency, or "otherwise." Payment for all items is scheduled in the home health PPS episode payment that the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision include:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

Carrier Claims Processing

The Common Working File (CWF) will reject claims for services that should not be billed separately when a patient is under an established 60-day home health Plan of Care (POC) episode. For Part B services, those services include physical therapy (Type of Service W), Speech-Language Pathology (Type of Service W) and Occupational Therapy (Type of Service U). Rejected claims will be returned as denials using the following MSN and Remittance messages. For DMERCs, those services included are certain non-routine medical supplies listed below.

MSN Message:
"Medicare does not pay separately for this service." (Message 16.32)

Remittance Message:
"Claim/service denied/reduced because this procedure/service is not paid separately." (Message B15)

Non-Routine Medical Supplies (DMERCs)

When a beneficiary is in a 60-day episode, these items are included in the PPS episode payment. HHAs must bill for all supplies provided during the 60-day episode including those not related to the Plan of Care because of the consolidated billing requirements. The codes listed below were published in the ***Federal Register***.

A4212	Non coring needle or stylet
A4213	20+ cc syringe only
A4215	Sterile needle
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/drainage 2-way latex
A4315	Cath w/drainage 2-way silcne
A4316	Cath w/drainage 3-way
A4320	Irrigation tray
A4321	Cath therapeutic irrig agent
A4322	Irrigation syringe
A4323	Saline irrigation solution
A4326	Male external catheter
A4327	Fem urinary collect dev cup
A4328	Fem urinary collect pouch
A4329	External catheter start set
A4330	Stool collection pouch
A4335	Incontinence supply
A4338	Indwelling catheter latex
A4340	Indwelling catheter special
A4344	Cath index foley 2 way silicn
A4346	Cath indw foley 3 way
A4347	Male external catheter
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter

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A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag

A4355	Bladder irrigation tubing
A4356	Ext ureth clmp or compr dvc
A4357	Bedside drainage bag
A4358	Urinary leg bag
A4359	Urinary suspensory w/o leg bag
A4361	Ostomy face plate
A4362	Solid skin barrier
A4363	Liquid skin barrier
A4364	Ostomy/cath adhesive
A4365	Ostomy adhesive remover wipe
A4367	Ostomy belt
A4368	Ostomy filter
A4397	Irrigation supply sleeve
A4398	Ostomy irrigation bag
A4399	Ostomy irrig cone/cath w brs
A4400	Ostomy irrigation set
A4402	Lubricant per ounce
A4404	Ostomy ring each
A4421	Ostomy supply misc
A4455	Adhesive remover per ounce
A4460	Elastic compression bandage
A4462	Abdmnl drssng holder/binder
A4481	Tracheostoma filter
A4554	Disposable underpads, all sizes
A4622	Tracheostomy or larngectomy
A4623	Tracheostomy inner cannula
A4625	Trach care kit for new trach
A4626	Tracheostomy cleaning brush
A4649	Surgical supplies
A5051	Pouch clsd w barr attached
A5052	Clsd ostomy pouch w/o barr
A5053	Clsd ostomy pouch faceplate
A5054	Clsd ostomy pouch w/flange
A5055	Stoma cap
A5061	Pouch drainable w barrier at
A5062	Drnble ostomy pouch w/o barr
A5063	Drain ostomy pouch w/flange
A5071	Urinary pouch w/barrier
A5072	Urinary pouch w/o barrier
A5073	Urinary pouch on barr w/flng
A5081	Continent stoma plug
A5082	Continent stoma catheter
A5093	Ostomy accessory convex inse
A5102	Beside drain btl w/wo tube
A5105	Urinary suspensory
A5112	Urinary leg bag
A5113	Latex leg strap
A5114	Foam/fabric leg strap
A5119	Skin barrier wipes box pr 50
A5121	Solid skin barrier 6x6
A5122	Solid skin barrier 8x8
A5123	Skin barrier with flange
A5126	Disk / foam pad +or- adhesive
A5131	Appliance cleaner
A5149	Incontinence / ostomy supply
A6020	Collagen wound dressing
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate drsg >16 <=48 sq in
A6198	Alginate dressing > 48 sq in
A6199	Alginate drsg wound filler
A6200	Compos drsg <=16 no bdr
A6201	Compos drsg >16<=48 no bdr
A6202	Compos drsg >48 no bdr
A6203	Composite drsg <= 16 sq in
A6204	Composite drsg >16<=48 sq in
A6205	Composite drsg > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam drsg <=16 sq in w/o bdr
A6210	Foam drg >16<=48 sq in w/o b
A6211	Foam drg > 48 sq in w/o brdr
A6212	Foam drg <=16 sq in w/bdr
A6213	Foam drg >16<=48 sq in w/bdr
A6214	Foam drg > 48 sq in w/bdr
A6215	Foam dressing wound filler
A6219	Gauze <= 16 sq in w/bdr
A6220	Gauze >16 <=48 sq in w/bdr
A6221	Gauze > 48 sq in w/bdr
A6222	Gauze <=16 in no w / sal w/ o b
A6223	Gauze >16<=48 no w / sal w/ o b
A6224	Gauze > 48 in no w /sal w/ o b
A6228	Gauze <= 16 sq in water / sal
A6229	Gauze >16<=48 sq in watr / sal
A6230	Gauze > 48 sq in water / salne
A6234	Hydrocolld drg <=16 w / o bdr
A6235	Hydrocolld drg >16<=48 w / o b
A6236	Hydrocolld drg > 48 in w / o b
A6237	Hydrocolld drg <=16 in w / bdr
A6238	Hydrocolld drg >16<=48 w / bdr
A6239	Hydrocolld drg > 48 in w / bdr
A6240	Hydrocolld drg filler paste
A6241	Hydrocolloid drg filler dry
A6242	Hydrogel drg <=16 in w / o bdr
A6243	Hydrogel drg >16<=48 w / o bdr
A6244	Hydrogel drg >48 in w / o bdr
A6245	Hydrogel drg <= 16 in w / bdr
A6246	Hydrogel drg >16<=48 in w / b
A6247	Hydrogel drg > 48 sq in w / b
A6248	Hydrogel dressing, wound filler
A6251	Absorpt drg <=16 sq in w / o b
A6252	Absorpt drg >16 <=48 w / o bdr
A6253	Absorpt drg . 48 sq in w / o b
A6254	Absorpt drg <=16 sq in w / bdr
A6255	Absorpt drg >16<=48 in w / bdr
A6256	Absorpt drg > 48 sq in w / bdr
A6257	Transparent film <= 16 sq in
A6258	Transparent film >16<=48 in

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A6259	Transparent film > 48 sq in
A6261	Wound filler gel / paste / oz
A6262	Wound filler dry form / gram
A6266	Impreg gauze no h20 / sal / yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6405	Sterile elastic gauze / yd
A6406	Sterile non-elastic gauze / yd
K0277	Skin barrier solid 4x4 equiv
K0278	Skin barrier with flange
K0279	Skin barrier extended wear
K0280	Extension drainage tubing
K0281	Lubricant catheter insertion
K0407	Urinary cath skin attachment
K0408	Urinary cath leg strap
K0409	Sterile H20 irrigation solut
K0410	Male ext cath w / adh coating
K0411	Male ext cath w / adh strip
K0419	Drainable plstic pch w fcplt
K0420	Drainable rubber pch w fcplt
K0421	Drainable plstic pch w / o fp
K0422	Drainable rubber pch w / o fp
K0423	Urinary plstic pouch w fcplt
K0424	Urinary rubber pouch w fcplt
K0425	Urinary plstic pouch w / fp
K0426	Urinary hvy plstc pch w / o fp
K0427	Urinary rubber pouch w / o fp
K0428	Ostomy faceplt / silicone ring
K0429	Skin barrier solid ext wear
K0430	Skin barrier w flang ex wear
K0431	Closed pouch w st wear bar
K0432	Drainable pch w ex wear bar
K0433	Drainable pch w st wear bar
K0434	Drainable pch ex wear convex
K0435	Urinary pouch w ex wear bar
K0436	Urinary pouch w st wear bar
K0437	Urine pch w ex wear bar conv
K0438	Ostomy pouch liq deodorant
K0439	Ostomy pouch solid deodorant

Listed below are codes that were deleted on 12/31/99 and cross-walked to new codes on 01/01/00.

Old code	New "A" Code
A4363	A4369
A4363	A4370
A4363	A4371
K0277	A4372
K0278	A4373
K0279	A4374
K0419	A4375
K0420	A4376
K0421	A4377
K0422	A4378
K0423	A4379
K0424	A4380
K0425	A4381
K0426	A4382
K0427	A4383
K0428	A4384
K0428	A4385
K0429	A4386
K0430	A4387
K0431	A4388
K0432	A4389
K0433	A4390
K0434	A4391
K0435	A4392
K0436	A4393
K0437	A4394
K0438	A4395
K0439	A4396 ⌘

Routine Costs of Clinical Trials

"On June 7, 2000, the President of the United States issued an executive memorandum directing the Health Care Financing Administration (HCFA) to "explicitly authorize [Medicare] payment for routine patient care costs…and costs due to medical complications associated with participation in clinical trials." In keeping with the President's directive, this National Coverage Decision (NCD) serves to define the routine costs of clinical trials and identify the clinical trials for which payment for such routine costs should be made for eligible services furnished on or after September 19, 2000.

HCFA has developed a National Coverage Determination (NCD) which can be accessed and downloaded from the HCFA webpage at www.hcfa.gov/quality/8d.htm. This NCD states that Medicare covers: 1) the routine costs of clinical trials as well as, 2) reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. This instruction addresses routine costs of qualifying clinical trials including complications resulting from qualifying clinical trials. All other Medicare rules apply.

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Clinical Trial Services That Qualify for Coverage

Clinical trial services covered by Medicare must meet both the following requirements:

1. **Qualifying Trial.** In order to be covered, the service must be part of a trial that meets all of the following criteria in order to be considered a qualifying trial:

   a.) Evaluates a Medicare Benefit. The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category (e.g., physicians' service, durable medical equipment, diagnostic test) and is not statutorily excluded from coverage (e.g., cosmetic surgery, hearing aids).

   b.) Has a Therapeutic Intent. The trial must have a therapeutic intent (i.e., is not designed exclusively to test toxicity or disease pathophysiology).

   c.) Enrolls Diagnosed Beneficiaries. Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients in order to have a proper control group.

   d.) Has Desirable Characteristics. The desirable characteristics are listed in the NCD.

   ◆ **Deemed Trials.** Some trials are considered automatically deemed as having desirable characteristics. They include:

   Effective September 19, 2000

   - Trials funded by the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), HCFA, Department of Defense (DOD), and Department of Veterans Affairs (VA);

   - Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, HCFA, DOD and VA;

   - Trials conducted under an investigational new drug application (IND) reviewed by the Food and Drugs Administration (FDA); and

   - Drug trials that are exempt from having an IND under 21 CFR 312.2(b)(1) are deemed until the qualifying criteria are developed and the certification process is in place. At time the principal investigators of these trials must certify that the trials meet the qualifying criteria in order to maintain Medicare coverage of routine costs. This certification process will only affect the future status of the trial and will not be used to retroactively change the earlier deemed status.

   Until the Medicare clinical trials registry is established, the sponsors of both IND trials and IND-exempt trials must identify themselves by e-mail to clinicaltrials@hcfa.gov for administration, payment and program integrity purposes.

   ◆ **Self-Certified Trials**. In the future, a multiagency federal panel (see NCD for further details) will develop qualifying criteria that will indicate a strong probability that a trial exhibits the desirable characteristics as stated in the NCD. No trials are covered based upon self-certification at this time.

2. **Routine Costs.** Routine costs of a clinical trial include all items and services that are provided in either the experimental or the control arms of a trial except those listed below as not covered. Services provided to Medicare beneficiaries in both the experimental group and the control group are eligible for coverage provided that all other criteria in this instruction are met.

Routine costs do NOT include (and are therefore not covered):

- The investigational item or service, itself;
- Items and services:
  -For which there is no Medicare benefit category; or
  -Which are statutorily excluded; or
  -That fall under a national noncoverage policy;
- Items and services furnished solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; and
- Items and services provided solely to determine trial eligibility.

Routine costs DO include (and are therefore covered):

- Items or services that are typically provided absent a clinical trial (e.g., medically necessary conventional care);

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- Items and services required for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent);

- Items and services required for the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items and services that are medically necessary for the diagnosis or treatment of complications arising from the provision of an investigational item or service.

This national coverage policy is based upon the authority found in §1862(a)(1)(E) of the Social Security Act (Act). It is binding on all Medicare carriers, intermediaries, Peer Review Organizations, Health Maintenance Organizations, Competitive Medical Plans, Health Care Prepayment Plans, and Medicare+Choice organizations (§1852 (a)(1)(A) of the Act)."

Effective for dates of service on or after September 19, 2000, when submitting claims for services or items that meet the requirements as outlined in the final National Coverage Decision you must identify these services with the "QV" procedure code modifier. "QV" – "Item or service provided as routine care in an approved clinical trial" (The full coverage policy regarding clinical trials may be accessed at www.hcfa.gov/quality/8d.htm).

The modifier is line item specific and must be used to identify items and services that constitute medically necessary routine patient care or treatment of complications arising from a Medicare beneficiary's participation in a Medicare covered clinical trial. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the clinical management of the patient are not covered and may not be billed using the QV modifier. Items and services that are not covered by Medicare by virtue of a statutory exclusion or lack of a benefit category also may not be billed using the QV modifier. Finally, items and services customarily provided by the research sponsor free of charge for any enrollee in the trial may not be billed.

In addition to the QV modifier, providers must also report diagnosis code V70.5 (Health Examination of Defined Subpopulations) as a secondary diagnosis for patients participating in Medicare covered clinical trials.

The QV modifier and V70.5 diagnosis code will serve as your attestation that the service meets the Medicare coverage criteria (i.e., was furnished to a beneficiary who is participating in a Medicare qualifying clinical trial and represents routine patient care, including complications associated with qualifying trial participation.)
Submit separate line items for clinical trial services when billing other covered services not directly related to a Medicare qualifying clinical trial on the same claim.

When submitting claims with the QV procedure code modifier and V70.5 diagnosis code, the billing provider must include in the beneficiary's medical record the following information: trial name, sponsor, and sponsor-assigned protocol number. This information should not be submitted with the claim but must be provided if requested for medical review. A copy of the signed informed consent document must also be made readily available if requested for medical review.

Payment for these qualifying clinical trial services furnished on or after September 19, 2000, will be made based on the payment methodology applicable for the service that was furnished (e.g., physician fee schedule, lab fee schedule, DME fee schedule, reasonable charge). All applicable deductible and coinsurance rules apply to these services with one exception. Managed care enrollees will not be responsible for the Part A and Part B deductibles for covered clinical trial services billed as fee for service.

If you have a claim for a Medicare qualifying clinical trial service that has been denied for a date of service on or after September 19, 2000, the action you take to get the claim paid will depend on whether the service was initially submitted with the QV modifier and ICD-9 code.

Initial Claim Did Not Include the QV Modifier and ICD-9 Code V70.5.—If clinical trial routine care services on a claim are denied and were not identified as clinical trial services (i.e., the clinical trial modifier and ICD-9 code was not included), resubmit the services on a new claim with the QV modifier and ICD-9 code V70.5 for the care or medical complications arising from a Medicare qualifying clinical trial.

Denied Service Included the QV Modifier and ICD-9 Code.—If a service Medicare covers is billed with the QV modifier and ICD-9 code and initially denied (e.g., for medical necessity or utilization) contact us at 570-735-9445 and request an adjustment to the claim. If appropriate, we will adjust and pay the claim.

Payment Of Clinical Trial Services For Managed Care Enrollees.— Until Medicare capitation rates are adjusted to account for clinical trials, payment for clinical trial services furnished to beneficiaries enrolled in Medicare managed care plans will be made on a fee for service basis by the Medicare contractors that process fee for service claims. Providers will need to submit fee for

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service bills for Medicare covered clinical trial services furnished to managed care enrollees. The payment amounts will be based on the applicable Medicare fee schedules for such services. In addition, the Part A and

Part B deductibles are assumed to be met for covered clinical trial services billed as fee for service for managed care enrollees.⌘

Billing Correct Units of Service for Nebulizer Drugs

Recent audits by the Region A DMERC have revealed that some providers are billing nebulizer drugs using the number of milliliters dispensed, not milligrams/grams.

Suppliers of these items are reminded:

"The billing unit for most inhalation drugs is per milligram (mg.) of the drug dispensed. The billing unit of J7631, J7668, and J7669 is per 10 milligrams (10 mg.) of the drug dispensed. The billing unit of J7608 is per gram (gm.) of the drug dispensed. The billing unit of J2545 and J7682 is per 300 milligrams (300 mg.) of the drug dispensed."

An added reminder when billing HCPCS code E0590, dispensing fees:

1 KO modifier = 1 dispensing fee
1 KP + 1 KQ modifier = 1 dispensing fee

Please refer to the nebulizer policy in the Region A DMERC Supplier Manual for proper billing and coding requirements.⌘

2001 DMEPOS Fee Schedule

The 2001 DMEPOS Fee Schedule has not been finalized due to possible changes in the legislation. The fees will be available on the DMERC web site www.umd.nycpic.com or the Health Care Financing Administration homepage. The fee schedule will also be published in the March 2001 manual revision. If you do not have access to a web site, you may request a copy from our Freedom of Information Unit:

HealthNow
DMERC A
Attn: FOI
60 East Main St.
Nanticoke, PA 18634⌘

Lightweight Wheelchairs - K0003 and K0004

Suppliers are reminded of the coverage and payment rules for lightweight wheelchairs (K0003) and HIGH STRENGTH lightweight wheelchairs (K0004) (Region A Supplier Manual, Chapter 14.19).

A K0003 is covered when a patient:

a) cannot self-propel in a standard wheelchair using arms and/or legs, and
b) the patient can and does self-propel in a lightweight wheelchair.

A K0004 is covered when, in addition to qualifying for a K0003, the patient either:

1. engages in frequent activities that cannot be performed in a standard or lightweight wheelchair, or
2. the patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair AND spends at least two hours a day in the wheelchair.

Additionally, a HIGH STRENGTH lightweight wheelchair is rarely medically necessary if the expected duration of need is less than three months (e.g. post-operative recovery).

When billing for lightweight wheelchairs, please ensure that the wheelchair documented on the certificate of medical necessity and signed by the physician is the same base wheelchair that is provided to the beneficiary and billed to Medicare. For example, if the physician's prescription is submitted in addition to the CMN stating "lightweight wheelchair", the supplier must provide the K0003. It is the supplier's responsibility to ensure the physician is educated on the differences between the two chairs. Under no circumstances should a chair be upcoded or downcoded by the supplier, i.e. providing a K0004 when a K0003 is ordered on the CMN or billing for a K0004 when a K0003 was prescribed by the physician.⌘

Revised Fee Schedule for Hydrogel Dressings

HCFA has notified the DMERCS of an error with the 2000 & 2001 fee schedules for the following codes:

K0535 - gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. in. or less, without adhesive border, each dressing

K0536 - gauze, impregnated, hydrogel, for direct wound contact, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing

K0537 - gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. in., without adhesive border, each dressing.

YEAR	HCPCS	X-WALK STATE CODE 1/1/01	BASE	CEILING FEE	FLOOR	
2000 & 2001	K0535	A6231	CT	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	DE	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	MA	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	ME	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	NH	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	NJ	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	NY	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	PA	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	RI	$3.86	$4.46	$3.79
2000 & 2001	K0535	A6231	VT	$3.86	$4.46	$3.79
2000 & 2001	K0536	A6232	CT	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	DE	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	MA	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	ME	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	NH	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	NJ	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	NY	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	PA	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	RI	$5.69	$6.57	$5.58
2000 & 2001	K0536	A6232	VT	$5.69	$6.57	$5.58
2000 & 2001	K0537	A6233	CT	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	DE	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	MA	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	ME	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	NH	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	NJ	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	NY	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	PA	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	RI	$15.88	$18.30	$15.56
2000 & 2001	K0537	A6233	VT	$15.88	$18.30	$15.56⌘

HCPCS

Year 2001 HCPCS Codes

In the past, the HCPCS codes and descriptions of all new, modified, or discontinued (deleted) HCPCS codes have been published in the newsletter. However, due to the volume at this time, only the HCPCS codes are being published in this newsletter. The Region A DMERC Supplier Manual, Chapter 5, has been updated to indicate all Year 2000 and 2001 code activity and can be referenced for all HCPCS code descriptors. This update is included in the accompanying Region A DMERC Supplier Manual revision. Please utilize the table in Chapter 5, Section 5.6 to determine the action taken with each HCPCS code (i.e., A=Add, C=Change, D=Discontinue, etc.). The HCPCS Index at the end of the chapter has also been updated for easy reference.

Procedure codes that have been added, changed, or discontinued are listed below and on the following page, and are effective for dates of service on or after January 1, 2001.

New Codes

A4319	A6024	E0148	J2915	K0545
A4324	A6231	E0149	J2993	K0546
A4325	A6232	E0168	J2997	K0547
A4331	A6233	E0298	J3485	L3760
A4332	A7018	E0571	J7330	L3923
A4333	A7019	E0572	J7520	L8040
A4334	A7020	E0574	J7525	L8041
A4348	A7501	E0617	J8700	L8042
A4396	A7502	E0765	J9160	L8043
A4464	A7503	E0830	J9180	L8044
A4561	A7504	E1035	J9219	L8045
A4562	A7505	J0282	K0541	L8046
A4608	A7506	J1452	K0542	L8047
A6021	A7507	J1563	K0543	L8048
A6022	A7508	J2770	K0544	L8049
A6023	A7509	J2795		

Modified Codes (Descriptor Changes)

A4364	E0441	J7619	L1755	L1858	L1980	L2102
A4365	E0442	L1600	L1800	L1860	L1990	L2104
A6222	E0443	L1610	L1810	L1870	L2000	L2106
A6223	E0444	L1620	L1815	L1880	L2010	L2108
A6224	E0575	L1630	L1820	L1885	L2020	L2112
A9900	E1800	L1640	L1825	L1900	L2030	L2114
A9901	E1805	L1650	L1830	L1902	L2035	L2116
B4150	E1810	L1660	L1832	L1904	L2036	L2122
B4151	E1815	L1680	L1834	L1906	L2037	L2124
B4152	E1825	L1685	L1840	L1910	L2038	L2126
B4153	E1830	L1686	L1843	L1920	L2039	L2128
B4154	J0895	L1690	L1844	L1930	L2040	L2132
B4155	J1100	L1700	L1845	L1940	L2050	L2134
B4156	J2260	L1710	L1846	L1945	L2060	L2136
E0424	J3010	L1720	L1847	L1950	L2070	L3650
E0431	J7505	L1730	L1850	L1960	L2080	L3660
E0439	J7618	L1750	L1855	L1970	L2090	L3670

(Continued on page 12.)

Modified Codes (Descriptor Changes) (continued)

L3675	L3900	L3914	L3932	L3950	L3968	L4370
L3700	L3901	L3916	L3934	L3952	L3969	L4380
L3710	L3902	L3918	L3936	L3954	L3980	L4392
L3720	L3904	L3920	L3938	L3960	L3982	L4396
L3730	L3906	L3922	L3940	L3962	L3984	L4398
L3740	L3907	L3924	L3942	L3963	L3985	L5674
L3800	L3908	L3926	L3944	L3964	L3986	L5675
L3805	L3910	L3928	L3946	L3965	L4350	L5979
L3807	L3912	L3930	L3948	L3966	L4360	

Discontinued (deleted) Codes

Reminder – There is a 3-month grace period for discontinued codes. This grace period applies to claims received by the DMERC before April 1, 2001, which include Year 2000 discontinued codes for dates of service January 1, 2001 to March 31, 2001.

The following table indicates deleted codes and the corresponding crosswalk code.

Old Codes	New Codes	Old Codes	New Codes	Old Codes	New Codes
A5149	A4335, A4421	K0410	A4324	K0450	A4364
A4560	A4561, A4562	K0411	A4325	K0451	A4365
E1375	E0570	K0440	L8040	K0456	E0298
K0182	A7018	K0441	L8041	K0457	E0168
K0269	E0572	K0442	L8042	K0458	E0148
K0270	E0574	K0443	L8043	K0459	E0149
K0280	A4331	K0444	L8044	K0501	E0571
K0281	A4332	K0445	L8045	K0529	A7020
K0283	A7019	K0446	L8046	K0535	A6231
K0407	A4333	K0447	L8047	K0536	A6232
K0408	A4334	K0448	L8048	K0537	A6233
K0409	A4319	K0449	L8049		

The following deleted codes have no crosswalk codes.

A5065	E1383	J7615	J7650	J7665
A6020	E1384	J7620	J7651	J7670
E1377	E1385	J7625	J7652	J7672
E1378	J1562	J7627	J7653	J7675
E1379	J2994	J7630	J7654	ZZ010
E1380	J2996	J7640	J7655	
E1381	J7610	J7645	J7660	
E1382				

Level II National Modifier Changes

New Level II Modifier (effective 9/19/00)

QV - Item or service provided as routine care in a Medicare qualifying clinical trial.

Deleted Level II Modifiers (effective 12/31/00)

KK - Inhalation Solution Compounded from an FDA Approved formulation.

KL - Product characteristics defined in medical policy are met. ⌘

Tracheostoma Valves and Heat and Moisture Exchangers

Several new codes have been established to bill for tracheostoma valves and for tracheostoma heat and moisture exchangers. These codes are effective for dates of service on or after January 1, 2001.

A tracheostoma valve (A7501) is a device that is used by some laryngectomy patients who have had a tracheoesophageal puncture procedure and have a "voice prosthesis" in their tracheoesophageal puncture site. It consists of a plastic body which contains a thin silicone diaphragm. The valve body fits into a plastic housing which is held in place over the tracheostoma by an adhesive disc made of tape or foam. The diaphragm of the tracheostoma valve closes during speaking to allow air to flow from the trachea through the voice prosthesis and into the esophagus to produce speech. Without a tracheostoma valve, the patient with a tracheoesophageal voice prosthesis would have to occlude the opening of the tracheostoma with their finger in order to be able to speak.

A tracheostoma valve (A7501) is to be distinguished from a tracheostomy speaking valve (L8501). A tracheostomy speaking valve (L8501) is a device which is attached to a tracheostomy tube. During speaking, the diaphragm in this device closes to keep air from flowing out through the tracheostomy tube, and instead directs air to flow normally through the larynx. In contrast, the tracheostoma valve described by code A7501 is used over a tracheostomy stoma in a patient who has had their larynx removed and has a tracheoesophageal voice prosthesis, but who does not have a tracheostomy tube.

A tracheostoma heat and moisture exchanger is a system that is used by some patients with a tracheostoma to add warmth and water vapor to the air when they take in a breath. It consists of a plastic cassette/ holder which contains a filter made of foam, paper, or other material. The holder fits into a plastic housing which is held in place over the tracheostoma by an adhesive disc. A heat and moisture exchanger may be used by itself or in addition to a tracheostoma valve (A7501).

Below is a list of the new codes and the brand names and manufacturers of some of the products that would be billed using each code. Questions concerning the coding of other products should be directed to the SADMERC.

A7501 Tracheostoma valve, including diaphragm, each

Products: Blom-Singer Adjustable Tracheostoma Valve (InHealth Technologies), Bivona Tracheostoma Valve (Bivona), Bivona Tracheostoma Valve II (Bivona)

A7502 Replacement diaphragm/ faceplate for tracheostoma valve, each

Product: Blom-Singer Replacement Diaphragm/ Faceplate (InHealth Technologies)

A7503 Filter holder or filter cap, reusable, for use in a tracheostoma heat and moisture exchange system, each

Products: Blom-Singer HumidiFilter Holder (InHealth Technologies), Blom-Singer HumidiFilter ATSV Cap (InHealth Technologies), TrachiNaze Occlusion Cap (Kapitex Healthcare)

A7504 Filter, for use in a tracheostoma heat and moisture exchange system, each

Product: Blom-Singer Foam Filters (InHealth Technologies), TrachiNaze Filters (Kapitex Healthcare)

A7505 Housing, reusable, without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each

Products: Blom-Singer Tracheostoma Valve Housing (InHealth Technologies), Bivona Housing (Bivona)

A7506 Adhesive disc, for use in a heat and moisture exchange system and/or with a tracheostoma valve, any type, each

Products: Blom-Singer Adhesive Disc (InHealth Technologies), Bivona Adhesive Disc (Bivona)

A7507 Filter holder and integrated filter, without adhesive, for use in a tracheostoma heat and moisture exchange system, each

Product: Provox HME cassette (Atos Medical)

A7508 Housing and integrated adhesive, for use in a tracheostoma heat and moisture exchange system and/or with a tracheostoma valve, each

Products: Provox Adhesive (Atos Medical), Blom-Singer True Seal Adhesive Housings (InHealth Technologies), Blom-Singer Tracheostoma Baseplate (InHealth Technologies), TrachiNaze Baseplate (Kapitex Healthcare)

A7509 Filter holder and integrated filter, housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each

Products: Provox StomVent (Atos Medical), StomVent II (Atos Medical)⌘

Rollabout Chairs (E1031)

Rollabout chair (E1031) is covered as described in national HCFA policy (CIM 60-9):

(It is covered if it) "...has been prescribed by the patient's physician in lieu of a wheelchair. Coverage is limited to those roll-about chairs having casters of at least 5 inches in diameter and specifically designed to meet the needs of ill, injured, or otherwise impaired individuals.

> Coverage is denied for the wide range of chairs with smaller casters as are found in general use in homes, offices, and institutions for many purposes not related to the care or treatment of ill or injured persons. This type is not primarily medical in nature."

Rollabout chairs may be called by other names such as "transport" or mobile geriatric chairs ("geri-chairs"). However, regardless of any name used for a rollabout chair, the instructions given above present the only distinctions relevant to Medicare coverage.

In addition to other factors, a manual wheelchair coded as K0001-K0009 must not only have wheels larger than 5 inches, but the wheels must also be designed and positioned on the chair such that a patient would be able to readily reach and use them to propel himself in the chair. Chairs designed only to be pushed by the caregiver must not be coded as a wheelchair.

Because rollabout chairs are not wheelchairs, wheelchair accessory codes billed as attachments to rollabout chairs will be denied as having no related equipment.

A supplier wanting to know which code to use to describe a particular product should contact the Statistical Analysis DME Regional Carrier (SADMERC)- Palmetto Government Benefits Administration.

Please refer to page 12-46 of the Region A DMERC

Speech Generating Devices - New Codes

In a recent national coverage determination, the Health Care Financing Administration (HCFA) announced that "communicators" (Coverage Issues Manual 60-9) would be eligible for coverage for dates of service on or after January 1, 2001. Coverage is provided under the durable medical equipment benefit category.

In accordance with HCFA's coverage decision, seven temporary "K" codes have been established. These new codes are effective for dates of service on or after January 1, 2001.

K0541 - Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time

K0542 - Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes recording time

K0543 - Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device

K0544 - Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access

K0545 - Speech generating software program, for personal computer or personal digital assistant

K0546 -Accessory for speech generating device, mounting system

K0547 - Accessory for speech generating device, not otherwise classified

In addition, effective for dates of service on or after January 1, 2001, HCPCS code E1900 (Synthesized speech augmentative communication device with dynamic display) will no longer be valid for submission to the DMERCs.

Note that the establishment of a new code does not necessarily indicate coverage of an item. Until formal publication of the change in the Coverage Issues Manual or development of a regional medical review policy, claims for speech generating devices will be adjudicated based on individual consideration for dates of service on or after January 1, 2001.⌘

Limb Orthoses - Code Narrative Changes

In the 2001 HCPCS Update, the narratives for many base codes for limb orthoses (L1600 - L4398) have been revised to more clearly indicate whether the code describes a prefabricated or a custom fabricated orthosis.

A prefabricated orthosis is one which is manufactured in quantity without a specific patient in mind. It is preformed with a shape that generally conforms to the body part. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). A preformed orthosis is considered prefabricated even if it requires the attachment of straps and/or the addition of a lining and/or other finishing work. Multiple measurements may be taken of the body part to determine which stock size of a prefabricated (preformed) orthosis will provide the best fit. An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom fabricated orthosis is considered prefabricated.

A custom fabricated orthosis is one which is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of flat sheets, bars, etc. It involves substantial work such as vacuum forming, cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than just trimming, bending, or making other modifications to a substantially prefabricated item.

Prior to this revision, many of the codes for custom fabricated limb orthoses contained the term "molded-to-patient-model." Molded-to-patient-model describes the way that thermoplastic limb orthoses are custom fabricated. An impression of the specific body part is made (by means of a plaster or fiberglass cast, CAD-CAM technology, etc.) and this impression is then used to make a positive model (of plaster or other material) of the body part. The orthosis is then custom fabricated and molded on this positive model. In the revised narratives for limb orthoses, the term "molded-to-patient model" has been deleted and the term "custom fabricated" has been substituted.

If suppliers or manufacturers have a question about the correct code to use for their product, they should contact the SADMERC for a written coding determination.

A list of the limb orthosis codes affected by these changes can be found in the Year 2001 HCPCS Codes article on page 11 in this newsletter and the full narratives may be found in chapter 5, HCPCS, of the accom-

Ventilator Code Change - E0450 - Reminder

The following is a reminder based upon erroneously coded claims that have been received at the DMERC.

As of January 1, 2000, the descriptor for the code, E0450, was changed as follows: Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube). Therefore, E0450 must not be used to bill for a ventilator being used with a non-invasive interface.

Similarly, K0534, a respiratory assist device, having bi-level pressure capacity, with backup rate, used with invasive interface, should only be billed if it is being used with an invasive interface (e.g., tracheostomy tube).

E0460, a negative pressure ventilator, should obviously not be billed for a positive pressure ventilator being used to administer respiratory assistance via a nasal and/or oral mask interface.

Positive pressure respiratory assist devices used to deliver respiratory assistance via a non-invasive interface must be coded with K0532 (bi-level pressure device without a backup rate), or K0533 (bi-level pressure device with a backup rate).

Refer to the Respiratory Assist Devices medical review policy for coverage criteria, coding guidelines and documentation requirements concerning these two codes.⌘

Hip Orthosis and Related Devices

The following article is revised from its initial publication in the December 1996 Region A DME Medicare News (changes are in italics):

Hip abduction devices used to treat contractures in adults are correctly billed using code L2999, unlisted procedures for lower extremity orthosis. These items typically consist of cuffs which are placed around each thigh and are connected by a device which can be adjusted to vary the distance between the two cuffs. Examples (not all-inclusive) of this type device are: Comfy Hip and Knee Abductor Orthosis (Lenjoy Engineering), Hip and Knee Abductor (Restorative Care of America), Oscar HKO (Orthosis Corrective Systems), Safe Hip Abductor System (Restorative Medical), Therapy Concepts Hip-Knee-Orthosis (Therapy Concepts), Vari-Duct Hip and Knee Orthosis (Orthotic Rehab). *There are also similar hip orthoses that have incorporated a sacral belt.* Other specific L codes must not be used at this time for these devices. Claims for these devices must be coded as L2999 and accompanied by the manufacturer's name, brand name and model number of the product. The DMERC has determined that the medical necessity of this type device has not been established, and therefore, claims for these items will be denied.⌘

L1690

At the present time, only one product has been officially coded under L1690, Combination, bilateral, lumbosacral, hip, femur orthosis providing adduction and internal rotation control. This product is the S.W.A.S.H. Hip Orthosis, manufactured by Camp. This product is indicated for the treatment of hip abnormalities in children. L1690 should not be utilized for coding other hip orthoses.

If a manufacturer or supplier has a product they feel qualifies for HCPCS code L1690, they should contact the SADMERC for a written coding determination.⌘

Effective immediately you may contact the SADMERC customer service center toll-free at 877-735-1326 for assistance with your HCPCS coding inquiries.

Pessaries: New Codes

Effective for dates of service (DOS) on or after January 1, 2001, coding changes are established for pessaries. HCPCS code A4560 will be deleted and replaced by two separate codes as follows:

Code	Description	Change	Effective
A4560	Pessary	Deleted	DOS January 1, 2001*
A4561	Pessary, rubber, any type	Added	DOS January 1, 2001 and after
A4562	Pessary, non rubber, any type	Added	DOS January 1, 2001 and after

* Coding grace period applies.

As of the above effective date, pessaries coded either A4561 (rubber) or A4562 (such as those fabricated from silicone) are covered by the DMERCs when prescribed by the treating physician. Claims for A4560 received on or after April 1, 2001 that are for DOS on or after January 1, 2001 will be rejected as an invalid code.

If physicians wish to directly bill the DMERC for these pessaries, they are reminded that they must apply for a supplier number from the National Supplier Clearinghouse (NSC). They may be contacted at P.O. Box 100142, Columbia, SC 29202-3142; by toll-free telephone number (866) 238-9652; or online at the following website: www.palmettogba.com⌘

Nutrients Administered Orally

Code descriptions for enteral nutrients have been revised to specify that the codes represent only nutrients that are given through an enteral feeding tube. As a result, nutrients dispensed to the patient for oral administration must no longer be billed to the DMERC using codes B4150-B4156.

Enteral nutrition is the provision of nutritional requirements through a tube into the stomach or small intestine. Beneficiaries who are able to take nutrients by mouth (orally) do not qualify for the prosthetic benefit, and the nutrients as well as any related supplies are noncovered. In this situation claim submission is not required. However, if the beneficiary is not in a covered Part A stay and asks the supplier to submit a claim, code A9270 must be used to bill the DMERC for nutrients provided for oral administration.⌘

External Cardiac Defibrillators

A new code has been established for automated external cardiac defibrillators.

E0617 External defibrillator with integrated electrocardiogram analysis

This code is effective for dates of service on or after January 1, 2001. Suppliers are reminded that the establishment of a unique code for a particular product does not necessarily indicate coverage.⌘

Medical Policy

Statement of Certifying Physician for Therapeutic Shoes Revised

The suggested form suppliers of therapeutic shoes for diabetics are to have completed and signed prior to submitting a claim to the DMERC has been revised. The revision clarifies for the certifying physician that all the statements on the form (not just those relating to foot deformity) should be circled, **only** if they apply.

The person signing this form must be a **certifying** physician. The certifying physician must be an **M.D.** or **D.O.** A podiatrist (D.P.M.) may not sign this form.

The prescribing physician, who issues the order for the shoes, may be an M.D., D.O. or D.P.M.

Suppliers are also reminded that merely receiving a signed statement from the certifying physician does not necessarily allow them to add a ZX modifier to the claim for the shoes. The statements on the form that are circled must indicate that the coverage criteria of the DMERC medical policy on Therapeutic Shoes for Diabetics have been fulfilled in order to properly apply the ZX modifier to the claim.⌘

Infusion Pumps: Inotropic Drug Monitoring / Epoprostenol

A revision of the external infusion pump policy is included in the accompanying December 2000 Supplier Manual Revision allowing use of either invasive hemodynamic monitoring or thoracic electrical bioimpedance, also known as impedance cardiography, in order to qualify a patient for Medicare coverage of inotropic drugs in the treatment of congestive heart failure.

Although the effective date of the revised policy is January 1, 2001, the results for this alternative form of cardiac monitoring will be considered with claims for dates of service on or after July 1, 1999.

Documentation requirements for epoprostenol have been changed in the current policy revision to coincide with the coverage criteria changes published in the September 2000 Supplier Manual Revision number 15.⌘

Ostomy Supplies

Supplier Notice 2000-31
November 1, 2000

The medical review policy on Ostomy Supplies contains guidelines on the usual maximum amount of supplies allowed. Some of these guidelines are being revised to increase the usual maximum amount (see table).

Usual Maximum Quantity of Supplies

Code	#/month	#/6 month	Code	#/month	#/6 month
A4357	1		A5062	20	
A4361		3	A5063	20	
A4362	20		A5071	20	
A4364	4		A5072	20	
A4367	1		A5073	20	
A4397	4		A5081	31	
A4398		2	A5082	1	
A4399		2	A5093	10	
A4402	4		A5102		2
A4404	10		A5119		3
A4455		16	A5121	20	
A5051	60		A5122	20	
A5052	60		A5123	20	
A5053	60		A5126	10	
A5054	60		A5131	1	
A5055	31		A6216	60	
A5061	20		A6265	40	

The current policy restrictions on the medical necessity of closed pouches (A5051-A5054, A4387) are rescinded.

Suppliers are reminded that there should be documentation in the patient's medical record supporting the type and amount of supplies ordered. This is particularly important when the patient's needs are greater than the "usual Maximum quantity" for the type of supplies that they use.

The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals. This information does not have to be routinely sent to the DMERC but must be made available to the DMERC upon request.

The Ostomy Supplies policy will be revised to include this information.

These changes are effective for claims with dates of service on or after October 1, 2000.⌘

Claims Processing for Breast Prosthesis

Supplier Notice 2000-33
November 14, 2000

In early September, the Region A DMERC instituted a claim processing edit for breast prosthesis coded with HCPCS Codes L8020 and L8030. The edit prevents payment for more than one of the above HCPCS Codes per side, on a given date of service. Although we recognize in the past, claims for multiple items per side were being paid, those claims were being paid in error. The purpose of this edit is to assure proper payment is only made for covered items and that we do not reimburse for the same or similar items. Reimbursement cannot be made for different types of the same items or for spare or back-up items.

Since the implementation of that edit, it has come to our attention that the supplier community has received inaccurate information related to coverage of the breast prosthesis benefit. The purpose of this bulletin is to correct those inaccuracies and clarify the coverage policy.

Initial Coverage Criteria

The DMERC will pay for only one (1) prosthesis (either an L8030 or L8020) per side on a given date of service. Two prostheses (one per side) are allowed for those patients who have had bilateral mastectomies. Suppliers must use the "RT "and "LT "modifiers to delineate the side or sides being billed. Claims received with more than one item billed per side will have all but one of the items per side denied. Appeal rights apply in cases where there is a disagreement with the decision.

The DMERC will adjudicate a claim for a different type (L8030 versus L8020) same side prosthesis received on a subsequent date of service that is based on a change in the patient's medical condition. Claims related to a change in medical condition should be documented by the submittal of a new prescription. The new prescription should include narrative explaining the need for the different type of prosthesis.

Subsequent claims billed as assigned for a different type same side prosthesis that are not based on a change in medical condition will be denied as a duplicate item. Unassigned claims with a similar scenario will be developed before being adjudicated.

Replacement Coverage Criteria

We are aware that incorrect information is being circulated that DMERC A will only allow a breast prosthesis to be replaced once every five (5) years. The truth is that there has been no change to the replacement policy as a result of the implementation of the claim processing edit. Medicare coverage allows for a breast prosthesis to be replaced whenever necessary when the reason for that replacement is either a change in the patient's medical condition or the item is damaged or worn, causing the item to become no longer useable.

Claims for replacement due to damage or wear do not require that a new physician prescription be submitted. In those cases, the supplier must only retain documentation to support the need for replacement. If the reason for the replacement is that it is the result of a change in medical condition, a new prescription will be required.

Suppliers are reminded to use the "RP" modifier if the claim is for a replacement prosthesis. Please also note that for prostheses covered by warranty, replacement for damage or wear is only reimbursable after the warranty period has expired.

Appeals

If a supplier believes that claims have not been adjudicated in accordance with the criteria specified in this article, the appeal procedures should be followed.⌘

Support Surfaces - Group 3 - Policy Revision

A revision of the Pressure Reducing Support Surfaces - Group 3 medical policy is included in the accompanying Region A DMERC Supplier Manual Revision. The DMERC policy incorporates recent revisions made to the national policy in Coverage Issues Manual Section 60-19.⌘

Lower Limb Prosthesis

A recent audit of the Lower Limb Prosthesis policy has revealed that medical documentation describing the patient's functional level and prescription issues has not been sufficient. This provides an opportunity to focus on key elements of the policy for educational purposes. This information will be useful for review, and may be referenced in the Lower Limb Prosthesis Policy in the Region A DMERC Supplier Manual.

The functional level is a measurement of the capacity and potential of the patient to accomplish his/her expected, post-rehabilitation, daily function. The functional classification is used by the DMERC to establish the medical necessity only of prosthetic knees, feet and ankles. The clinical assessments of the patient's rehabilitation potential should be based on the following classification levels:

- Level 0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and prosthesis does not enhance the quality of life or mobility.
- Level 1: Has the ability or potential to use prosthesis for transfers or ambulation on level services at fixed cadence. Typical of the limited and unlimited household ambulator.
- Level 2: Has the ability or potential for ambulation with the ability to transfer low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
- Level 3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activities that demands prosthetic utilization beyond simple locomotion.
- Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of a child, active adult, or athlete.

The records should document the patient's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case.

Coverage is extended only if there is sufficient clinical documentation of functional need for the technology or design feature of a given type of foot and/or knee. This documentation is to be maintained in the physician's or prosthetist's files.

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

The order for the prosthesis including all components which is signed and dated by the ordering physician, must be kept on file by the prosthetist. When submitting a prosthetic claim to the DMERC, the billed code for knees, feet and ankles components must be submitted with modifiers K0-K4, indicating the expected functional

Miscellaneous

Supplier Standards

Medicare regulations have defined standards that a supplier must meet to receive and maintain a supplier number. These standards can be found as part of HCFA's Law, Regulations, Manuals and CD-ROM and are effective December 11, 2000. Chapter 2 of the accompanying Region A DMERC Supplier Manual Revision contains the new standards. All questions regarding the supplier standards should be directed to the National Supplier Clearinghouse at telephone number (866) 238-9652. ⌘

Medicare Secondary To Department of Labor

Claims submitted to the DMERC for secondary payments subsequent to denials by the Department of Labor (DOL) are processed as directed in section 3330.6 of the MCM.

If the DOL has denied some or all of the services for any reason except for an invalid or missing supplier number or insufficient documentation, submit the claim to the DMERC office with a copy of the DOL notice that includes the reason(s) for denial.

Claims denied by the DOL for missing or invalid supplier number or for insufficient documentation should not be

Comprehensive Error Rate Testing

In order to improve the processing and medical decision making involved with payment of Medicare claims, HCFA began a new program effective August 2000. This program is called Comprehensive Error Rate Testing (CERT) and is being implemented in order to achieve goals of the Government Performance and Results Act of 1993, which sets performance measurements for Federal agencies.

Under CERT, an independent contractor (DynCorp of Richmond, Virginia) will select a random sample of claims processed by each Medicare contractor. DynCorp's medical review staff (to include nurses, physicians, and other qualified healthcare practitioners) will then verify that contractor decisions regarding the claims were accurate and based on sound policy. HCFA will use the DynCorp findings to determine underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by DynCorp. The first will be the durable medical equipment carriers (DMERCs). On a monthly basis, DynCorp will request a small sample of claims--approximately 200--from each DMERC, as the claims are entered into their system. DynCorp will follow the claims until they're adjudicated, and then compare the DMERC's final claims decision with its own. Instances of incorrect processing (e.g., due to questions of medical necessity, inappropriate application of medical review policy, etc.) become targets for correction or improvement, in appropriate ways. Consequently, it is HCFA's intent that the Medicare Trust Fund benefits from improved claims accuracy and payment processes.

How else are suppliers impacted by CERT?

Suppliers of the sampled claims will be asked during the course of the DynCorp review, to provide additional information (e.g., medical records, certificates of medical necessity, etc.) for DynCorp staff to verify services billed were delivered, medical necessity, and appropriateness of claims processing procedures. If contacted, you will be provided with the details regarding the needed information and the name of a contact person.

General questions regarding the CERT initiative may be directed to Laura Castelli, DynCorp Project Director for the CERT Program, at 804-264-1778. Otherwise, suppliers will be contacted ONLY if their claim(s) is selected and additional information is required by DynCorp.⌘

Offset Information Requests

To request offset information, fax a copy of the remittance which indicates an offset to the Accounting Unit (570) 735-9594. The following information will be faxed back to the provider: the beneficiary's name, Medicare number, and the document control number (DCN) of the original overpayment. All other information related to the offset is provided in the original overpayment letter.

Request for Immediate Offset

To request an immediate offset of an overpayment, fax a copy of the first page of the overpayment letter to the Accounting Unit at (570) 735-9594. Please indicate clearly on the fax that immediate offset is being requested. Remember that total payment amounts of the assigned claims that make up the overpayment must be recouped prior to the date referenced in our original overpayment refund letter, or interest will be assessed on the remaining balance.

Overpayment Refunds

Follow these procedures to submit a voluntary refund to Medicare:

- Submit a check or money order, payable to Medicare-Region A DMERC
- Clearly identify the incorrect payment by providing a copy of the portion of the Provider Remittance Notice that shows the incorrect payment
- Enclose the prescribed overpayment refund form (published on page 27 of the September 1999 *DMERC Medicare News*) that has been completed with all the pertinent information. Minimum information includes the HIC number of the beneficiary, date of service, procedure codes involved, and the reason for the overpayment. If only one procedure code has been paid in error, be sure to identify which code was incorrectly paid.

If an overpayment has been identified by Medicare, please attached a copy of the overpayment letter with your refund. Submit a check or money order payable to Medicare - Region A DMERC.

To appeal an overpayment request, you must request a fair hearing.⌘

The Hype About HIPAA

If you haven't heard of HIPAA, you have a lot of catching up to do!

In 1996 Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care payers, plans, and providers. This will enable the entire health care industry to communicate electronic data using a single set of standards thus eliminating all nonstandard formats currently in use. Once these standards are in place, a health care provider will be able to submit a standard transaction for eligibility, authorization, referrals, claims, or attachments containing the same standard data content to any health plan. This will "simplify" many clinical, billing, and other financial applications and reduce costs.

The Transaction Final Rule is the first of the Administrative Simplification requirements to be published in the ***Federal Register***. It was published on August 17, 2000 and requires providers to use the applicable standards for electronic transactions such as: submitting claims; receiving remittance advice statements; querying patient eligibility; checking claim status; requesting prior authorization where required for certain items of durable medical equipment; or requesting payment for the limited number of drugs covered by Medicare. These standards will be fully implemented October 16, 2002 (October 16, 2003 for small health plans). When fully implemented, Medicare contractors and other health care payers will be prohibited from accepting or issuing transactions that do not meet the new standards.

Health care providers and suppliers who conduct business electronically are urged to begin considering what steps they may need to take to upgrade their software to conform to the new standards. This can be done either independently or through commercial vendors. Health providers can also consider arranging for the services of a commercial clearinghouse or billing service knowledgeable about the new requirements to translate data on their behalf.

A copy of the Transaction and Code Set Final Rule, as well as more information on the full range of Administrative Simplification requirements (including identifiers, security and privacy of health information proposed rules) can be obtained from the following web site: http://aspe.hhs.gov/admnsimp/.

Look for further important HIPAA information in upcoming issues of this publication.⌘

COB Contractor Fact Sheet for Providers

The Health Care Financing Administration (HCFA) has embarked on an important initiative to further expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program. HCFA awarded the Coordination of Benefits (COB) contract to consolidate the activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries.

The awarding of the COB Contract provides many benefits for employers, providers, suppliers, third party payers, attorneys, beneficiaries, and Federal and State insurance programs. All Medicare Secondary Payer (MSP) claims investigations will be initiated from, and researched at the COB Contractor. This will no longer be a function of your local Medicare fiscal intermediary (FI) or carrier. Implementing this single-source development approach will greatly reduce the amount of duplicate MSP investigations. This will also offer a centralized, one-stop customer service approach, for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Funds. The COB Contractor will provide customer service to all callers from any source, including but not limited to beneficiaries, attorneys/other beneficiary representatives, employers, insurers, providers, and suppliers.

Information Gathering

Medicare generally uses the term Medicare Secondary Payer or “MSP” when the Medicare program is not responsible for paying a claim first. The COB contractor will use a variety of methods and programs to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. In such situations, the other health plan has the legal obligation to meet the beneficiary’s health care expenses first before Medicare.

(Continued on page 23.)

The table below describes a few of these methods and programs.

Method/Program	***Description***
Initial Enrollment Questionnaire (IEQ)	Beneficiaries are sent a questionnaire about other insurance coverage approximately three (3) months before they are entitled to Medicare.
IRS/SSA/HCFA Data Match	Under the Omnibus Budget Reconciliation Act of 1989, employers are required to complete a questionnaire that requests Group Health Plan (GHP) information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.
MSP Claims Investigation	This activity involves the collection of data on other health insurance that may be primary to Medicare based on information submitted on a medical claim or from other sources.
Voluntary MSP Data Match Agreements	Voluntary Agreements allow for the electronic data exchange of GHP eligibility and Medicare information between HCFA and employers or various insurers.

Provider Requests for Claims Payment

FIs and carriers will continue to process claims submitted for primary or secondary payment. Claims processing will not be a function of the COB Contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should continue to be directed to your local FI or carrier. If a provider submits a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the COB Contractor. This investigation will be performed with the provider or supplier that submitted the claim. MSP investigations will no longer be a function of your local FI or carrier. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

Medicare Secondary Payer Auxiliary Records in HCFA's Database

The COB Contractor will be the sole authority in ensuring the accuracy and integrity of the MSP information contained in HCFA's database (i.e. Common Working File). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as necessary, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary and/or spousal changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the COB Contractor. HCFA also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage, and to report this information when filing claims with the Medicare Program.

Contacting the COB Contractor

Effective January 1, 2001, please refer all MSP inquiries; including, the reporting of potential MSP situations, changes in a beneficiary's insurance coverage, changes in employment, and general MSP questions/concerns to the COB Contractor. Continue to call your local FI and/or carrier regarding claims-related questions. **The COB Contractor's Customer Call Center toll free number is 1-800-999-1118 or TDD/TYY 1-800-318-8782.** Customer service representatives are available to assist you from 8 AM to 8 PM, Monday through Friday, Eastern Standard Time, except holidays. Clip and post this section in a handy place for access by your office and billing staff.⌘

SADMERC

The articles in this section were submitted by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC); all questions pertaining to these articles should be directed to the SADMERC at 877-735-1326.

Manufacturer Questions Regarding SADMERC Coding Decisions

Manufacturers can submit their medical devices to the SADMERC for review and a HCPCS coding decision. The SADMERC will review the submitted material related to the product. Once a consensus coding decision is established, the SADMERC sends written notification of the coding decision to the manufacturer.

Frequently, manufacturers have questions regarding their coding decision. Due to the large volume of product reviews, SADMERC responses can not be provided over the phone. For any questions related to a HCPCS coding decision, the manufacturer must submit a letter with specific questions. The SADMERC can only respond to questions related to the coding decision and review process. The DMERC's should be contacted for any information regarding the following:

- Coverage and Utilization
- Eligibility
- Claim Inquiries/Forms
- Required documentation
- Publications
- CMN information
- Allowables for items priced by reasonable charge or individually considered
- Type of Service or Place of Service

Please mail SADMERC correspondence to the following address:

SADMERC
P.O. Box 100143
Columbia, S.C. 29202-3143
ATTN: Mary Pinkston or Bonnie Brooks
HCPCS Analyst⌘

L0430 Classification List

The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is in the process of creating a classification list for products that would be classified as L0430, (TLSO, anterior-posterior-lateral control, with interface material, custom fitted). The SADMERC has been directed by the Health Care Financing Administration (HCFA) to develop this classification list. Upon completion and publication of this list, only the products included on the list may be billed using the code L0430. If a manufacturer or supplier thinks that another product meets the definition of this code, they should contact the SADMERC for a coding determination. Suppliers of L0430 may wish to contact their manufacturing source to determine if the manufacturer has provided the required information to the SADMERC.⌘

SADMERC Toll-Free HCPCS Coding Assistance

The Health Care Financing Administration and Palmetto GBA are pleased to announce the installation of toll-free provider lines for all Medicare providers. Effective immediately you may contact the SADMERC customer service center at 877-735-1326 for assistance with your HCPCS coding inquiries. This transition to toll-free lines reflects Medicare's increased focus on customer service for providers.⌘

Supplier Notices

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

3rd Quarter Update: Region A DMERC Drug Fees

Supplier Notice 2000-24
August 30, 2000

The fees listed below were effective July 1, 2000.

DRUG FEES

HCPCS CODE	DESCRIPTION	DOSAGE	FEE
J0285	AMPHOTERICIN B	50 MG	$16.95
J0286	AMPHOTERICIN B, ANY LIPID FORMULATION	50 MG	$88.66
J0895	DEFEROXAMINE MESYLATE	500 MG/5CC	$12.03
J1170	HYDROMORPHONE	4 MG	$0.50
J1250	DOBUTAMINE HYDROCHLORIDE	250 MG	$4.28
J1325	EPOPROSTENAL	0.5 MG	$11.02
J1455	FOSCARNET SODIUM	1000 MG	$11.99
J1570	GANCICLOVIR SODIUM	500 MG	$33.89
J1820	INSULIN, INJECTION	UP TO 100 UNITS	$2.18
J2175	MEPERIDINE HYDROCHLORIDE	100 MG	$0.60
J2260	MILRINONE LACTATE	5 ML	$40.80
J2270	MORPHINE SULFATE	10 MG	$0.62
J2271	MORPHINE SULFATE	100 MG	$13.85
J2275	MORPHINE SULFATE, PF, STERILE SOL	10 MG	$2.38
J2545	PENTAMIDINE FOR AEROSOL INHALER	300 MG	$106.51
J2920	METHYLPREDNISOLONE SODIUM SUCCINATE	40 MG	$2.08
J2930	METHYLPREDNISOLONE SODIUM SUCCINATE	125 MG	$3.54
J3010	FENTANYL CITRATE	2 ML	$1.04
J3370	VANCOMYCIN HCL	500 MG	$5.20
J7500	AZATHIOPRINE, ORAL, TAB	50 MG	$1.24
J7501	AZATHIOPRINE, PARENTERAL	100 MG	$107.91
J7502	CYCLOSPORINE, ORAL	100 MG	$5.23
J7506	PREDNISONE,ORAL	5 MG	$0.02
J7507	TACROLIMUS, ORAL	1 MG	$2.66
J7508	TACROLIMUS, ORAL	5 MG	$13.32
J7509	METHYLPREDNISOLONE, ORAL	4 MG	$0.50
J7510	PREDNISOLONE, ORAL	5 MG	$0.03
J7513	DACLIZUMAB, PARENTERAL	25 MG	$397.29
J7515	CYCLOSPORINE, ORAL	25 MG	$1.31
J7517	MYCOPHENOLATE MOFETIL, ORAL	250 MG	$2.24
J9000	DOXORUBICIN HCL	10 MG	$50.96
J9001	DOXARUBICIN HCL ALL LIPID FORMS.	10 MG	$335.47
J9040	BLEOMYCIN SULFATE	15 UNITS	$289.37
J9065	CLADRIBINE	1 MG	$53.47
J9100	CYTARABINE	100 MG	$5.94

(Continued on page 26.)

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
The bulletins are available at no cost from our website at www.umd.nycpic.com.

HCPCS CODE	DESCRIPTION	DOSAGE	FEE
J9110	CYTARABINE	500 MG	$23.75
J9190	FLUOROURACIL	500 MG	$2.73
J9200	FLOXURIDINE	500 MG	$129.56
J9208	IFOSFAMIDE	1 GM	$149.19
J9265	PACLITAXEL	30 MG	$173.50
J9280	MITOMYCIN	5 MG	$124.53
J9290	MITOMYCIN	20 MG	$413.72
J9360	VINBLASTINE SULFATE	1 MG	$4.10
J9370	VINCRISTINE SULFATE	1 MG	$33.98
J9375	VINCRISTINE SULFATE	2 MG	$67.96
J9380	VINCRISTINE SULFATE	5 MG	$154.57
J9390	VINORELBINE TARTRATE	10 MG	$75.51
Q9920	EPOETIN		$10.00

NEBULIZER DRUG FEES

HCPCS CODE	MODIFIER	DESCRIPTION	FEE
J7051		STERILE SALINE OR WATER	$0.21
J7608	KO	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	$5.06
J7608	KP	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	$5.06
J7608	KQ	ACETYLCYSTEINE INHALATION SOLUTION UNIT DOSE FORM	$4.53
J7618		ALBUTEROL, CONCENTRATED FORM	$0.14
J7619	KO	ALBUTEROL, UNIT DOSE FORM	$0.47
J7619	KP	ALBUTEROL, UNIT DOSE FORM	$0.47
J7619	KQ	ALBUTEROL, UNIT DOSE FORM	$0.14
J7628		BITOLTEROL MESYLATE, CONCENTRATED FORM	$0.25
J7629	KO	BITOLTEROL MESYLATE, UNIT DOSE FORM	$0.33
J7629	KP	BITOLTEROL MESYLATE, UNIT DOSE FORM	$0.33
J7629	KQ	BITOLTEROL MESYLATE, UNIT DOSE FORM	$0.25
J7631	KO	CROMOLYN SODIUM, UNIT DOSE FORM	$0.23
J7631	KP	CROMOLYN SODIUM, UNIT DOSE FORM	$0.23
J7631	KQ	CROMOLYN SODIUM, UNIT DOSE FORM	$0.12
J7635		ATROPINE, CONCENTRATED FORM	$0.13
J7636	KO	ATROPINE, UNIT DOSE FORM	$0.34
J7636	KP	ATROPINE, UNIT DOSE FORM	$0.34
J7636	KQ	ATROPINE, UNIT DOSE FORM	$0.13
J7637		DEXAMETHASONE, CONCENTRATED FORM	$0.10
J7638	KO	DEXAMETHASONE, UNIT DOSE FORM	$0.21
J7638	KP	DEXAMETHASONE, UNIT DOSE FORM	$0.21
J7638	KQ	DEXAMETHASONE, UNIT DOSE FORM	$0.10
J7639	KO	DORNASE ALPHA, UNIT DOSE FORM	$15.12
J7639	KP	DORNASE ALPHA, UNIT DOSE FORM	$15.12
J7639	KQ	DORNASE ALPHA, UNIT DOSE FORM	$15.04
J7642		GLYCOPYRROLATE, CONCENTRATED FORM	$0.31
J7643	KO	GLYCOPYRROLATE, UNIT DOSE FORM	$0.83
J7643	KP	GLYCOPYRROLATE, UNIT DOSE FORM	$0.83
J7643	KQ	GLYCOPYRROLATE, UNIT DOSE FORM	$0.31
J7644	KO	IPRATROPIUM BROMIDE, UNIT DOSE FORM	$3.34
J7644	KP	IPRATROPIUM BROMIDE, UNIT DOSE FORM	$3.34
J7644	KQ	IPRATROPIUM BROMIDE, UNIT DOSE FORM	$2.92
J7648		ISOETHARINE HCL, CONCENTRATED FORM	$0.17

(Continued on page 27.)

HCPCS CODE	MODIFIER	DESCRIPTION	FEE
J7649	KO	ISOETHARINE HCL, UNIT DOSE FORM	$0.21
J7649	KP	ISOETHARINE HCL, UNIT DOSE FORM	$0.21
J7649	KQ	ISOETHARINE HCL, UNIT DOSE FORM	$0.17
J7658		ISOPROTERENOL HCL, CONCENTRATED FORM	$0.31
J7659	KO	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.40
J7659	KP	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.40
J7659	KQ	ISOPROTERENOL HCL, UNIT DOSE FORM	$0.31
J7668		METAPROTERENOL SULFATE, CONCENTRATED FORM	$0.25
J7669	KO	METAPROTERENOL SULFATE, UNIT DOSE FORM	$1.10
J7669	KP	METAPROTERENOL SULFATE, UNIT DOSE FORM	$1.10
J7669	KQ	METAPROTERENOL SULFATE, UNIT DOSE FORM	$0.25
J7680		TERBUTALINE SULFATE, CONCENTRATED FORM	$1.96
J7681	KO	TERBUTALINE SULFATE, UNIT DOSE FORM	$2.17
J7681	KP	TERBUTALINE SULFATE, UNIT DOSE FORM	$2.17
J7681	KQ	TERBUTALINE SULFATE, UNIT DOSE FORM	$1.96
J7682	KO	TOBRAMYCINE, UNIT DOSE FORM, 300MG	$40.51
J7682	KP	TOBRAMYCINE, UNIT DOSE FORM, 300MG	$40.51
J7682	KQ	TOBRAMYCINE, UNIT DOSE FORM, 300MG	*IC
J7683		TRIAMCINOLONE, CONCENTRATED FORM	$0.04
J7684	KO	TRIAMCINOLONE, UNIT DOSE FORM	$0.15
J7684	KP	TRIAMCINOLONE, UNIT DOSE FORM	$0.15
J7684	KQ	TRIAMCINOLONE, UNIT DOSE FORM	$0.04

ORAL ANTIEMETIC DRUG FEES

HCPCS CODE	DESCRIPTION	FEE
Q0163	DIPHENHYDRAMINE HYDROCHLORIDE, 50MG	$0.02
Q0164	PROCHLORPERAZINE MALEATE, 5MG	$0.54
Q0165	PROCHLORPERAZIEN MALEATE, 10MG	$0.81
Q0166	GRANISETRON HYDROCHLORIDE, 1MG	$44.69
Q0167	DRONABINOL, 2.5MG, ORAL	$3.18
Q0168	DRONABINOL, 5MG, ORAL	$6.30
Q0169	PROMETHAZINE HYDROCHLORIDE, 12.5MG, ORAL	$0.24
Q0170	PROMETHAZINE HYDROCHLORIDE, 25MG, ORAL	$0.02
Q0171	CHLORPROMAZINE HYDROCHLORIDE, 10MG, ORAL	$0.07
Q0172	CHLORPROMAZINE HYDROCHLORIDE, 25MG, ORAL	$0.09
Q0173	TRIMETHOBENZAMIDE HYDROCHLORIDE, 250MG, ORAL	$0.45
Q0174	THIETHYLPERAZINE MALEATE, 10MG, ORAL	$0.54
Q0175	PERPHENAZINE, 4MG, ORAL	$0.57
Q0176	PERPHENAZIEN, 8MG, ORAL	$0.93
Q0177	HYDROXYZINE PAMOATE, 25MG, ORAL	$0.25
Q0178	HYDROXYZINE PAMOATE, 50MG, ORAL	$0.26
Q0179	ONDANSETRON HYDROCHLORIDE, 8MG, ORAL	$25.15
Q0180	DOLASETRON MESYLATE, 100MG, ORAL	$65.21

*INDIVIDUAL CONSIDERATION

Attention: Accelerate Software Users

Supplier Notice 2000-25
August 30, 2000

Due to the transition, Accelerate software users will need to change the receiver ID in order to be able to continue to submit claims to the DMERC. The updated software to change the receiver ID will be available via the bulletin board system the week of September 18, 2000. Please watch the bulletin board system the third week of September for more details.

Oral Anticancer Drug Fees

Supplier Notice 2000-26
August 31, 2000

The fees listed below were effective July 1, 2000.

Manufacturers	Descriptors	Dosage	NDC Number/Code	Fee
GLAXO-WELLCOME	BUSULFAN	2mg Oral 1 Tab, per unit	000173-0713-25	$1.73
ROCHE LABORATORIES	CAPECITABINE	150 mg, Oral, 1 Tab per unit	00004-1100-13	$2.05
ROCHE LABORATORIES	CAPECITABINE	150 mg, Oral, 1 Tab per unit	00004-1100-22	$2.05
ROCHE LABORATORIES	CAPECITABINE	150 mg, Oral, 1 Tab per unit	00004-1100-51	$2.05
ROCHE LABORATORIES	CAPECITABINE	500 mg, Oral, 1 Tab per unit	00004-1101-13	$6.8
ROCHE LABORATORIES	CAPECITABINE	500 mg, Oral, 1 Tab per unit	00004-1101-16	$6.8
ROCHE LABORATORIES	CAPECITABINE	500 mg, Oral, 1 Tab per unit	00004-1101-51	$6.8
BRISTOL-MYERS	CYCLOPHOSPHAMIDE	25 mg Oral 1 Tab, per unit	00015-0504-01	$1.93
BRISTOL-MYERS	CYCLOPHOSPHAMIDE	50 mg Oral 1 Tab, per unit	00015-0503-01	$3.54
BRISTOL-MYERS	CYCLOPHOSPHAMIDE	50 mg Oral 1 Tab, per unit	00015-0503-02	$3.54
BRISTOL-MYERS	ETOPOSIDE	50 mg Oral 1 Tab, per unit	00015-3091-45	$48.48
GLAXO-WELLCOME	MELPHALAN	2 mg 1 Tab, per unit	00081-0045-35	$2.07
GLAXO-WELLCOME	MELPHALAN	2 mg 1 Tab, per unit	00173-0045-35	$2.07
LEDERLE LABS	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00005-4507-23	$2.91
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-4550-15	$2.91
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-4550-25	$2.91
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-03	$2.91
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-05	$2.91
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-06	$2.91
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-07	$2.91
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-10	$2.91
ROXANE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00054-8550-25	$2.91
ZENITH GOLDLINE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00182-1539-01	$2.91
ZENITH GOLDLINE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00182-1539-95	$2.91
SCHEIN	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00364-2499-01	$2.91
SCHEIN	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00364-2499-36	$2.91
MYLAN	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00378-0014-01	$2.91
MYLAN	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00378-0014-50	$2.91
RUGBY	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00536-3998-01	$2.91
RUGBY	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00536-3998-36	$2.91
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-02	$2.91
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-35	$2.91
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-45	$2.91
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-46	$2.91

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Manufacturers	Descriptors	Dosage	NDC Number/Code	Fee
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-47	$2.91
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-48	$2.91
BARR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00555-0572-49	$2.91
QUALITEST	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00603-4499-21	$2.91
URL	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00677-1610-01	$2.91
GENEVA	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00781-1076-01	$2.91
GENEVA	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00781-1076-36	$2.91
MAJOR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00904-1749-60	$2.91
MAJOR	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	00904-1749-73	$2.91
UDL	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	51079-0670-05	$2.91
DURAMED	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	51285-0509-02	$2.91
ESI LEDERLE	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	59911-5874-01	$2.91
SUperGEN	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	62701-0940-36	$2.91
SUperGEN	METHOTREXATE	2.5 mg Oral 1 Tab, per unit	62701-0940-99	$2.91
SCHERING	TEMOZOLOMIDE	5mg Oral 1 Tab, per unit	00085-1248-01	$5.70
SCHERING	TEMOZOLOMIDE	5mg Oral 1 Tab, per unit	00085-1248-02	$5.70
SCHERING	TEMOZOLOMIDE	20mg Oral 1 Tab, per unit	00085-1244-01	$22.80
SCHERING	TEMOZOLOMIDE	20mg Oral 1 Tab, per unit	00085-1244-02	$22.80
SCHERING	TEMOZOLOMIDE	100mg Oral 1 Tab, per unit	00085-1259-01	$114.00
SCHERING	TEMOZOLOMIDE	100mg Oral 1 Tab, per unit	00085-1259-02	$114.00
SCHERING	TEMOZOLOMIDE	250mg Oral 1 Tab, per unit	00085-1252-01	$285.00
SCHERING	TEMOZOLOMIDE	250mg Oral 1 Tab, per unit	00085-1252-02	$285.00

Attention Accelerate Software Users

Supplier Notice 2000-27
September 18, 2000

The updated Accelerate software is now available on the Bulletin Board System. Please follow the step by step instructions below to update your software. Be sure to complete steps 1 through 25 now. Steps 26 through 44 must be completed after Thursday September 21, 2000.

Steps to Update Accelerate Software

1. DIAL INTO THE BULLETIN BOARD SYSTEM
2. PUT IN YOUR SUBMITTER NUMBER AND PASS-WORD
3. GET TO THE MAIN MENU
4. CHOOSE OPTION G (SUPPORT FILES)
5. CHOOSE OPTION A (ACCELERATE UPDATES)
6. TYPE D TO DOWNLOAD
7. TYPE THE FILE NAME UPDATE.EXE
8. PRESS ENTER
9. CHOOSE Z MODEM
10. ONCE THE FILE HAS DOWNLOADED
11. CHOOSE R TO RETURN TO THE MAIN MENU
12. CHOOSE E TO EXIT
13. CLICK ON FILE AT THE TOP OF THE SCREEN
14. CLICK ON EXIT
15. YOU SHOULD NOW BE BACK AT THE TRANSMIT MENU IN THE SOFTWARE
16. PRESS ESCAPE
17. ARROW OVER TO THE WORD ESCAPE
18. PRESS ENTER
19. THIS WILL TAKE YOU TO ONE OF TWO PLACES - EITHER THE MEDBDME PROMPT OR THE UNITED HEALTHCARE MAIN MENU
20. IF YOU ARE AT THE MENU CHOOSE X TO EXIT
21. AT THE C:\MEDBDME PROMPT TYPE UPDATE
22. PRESS ENTER
23. ANSWER YES TO ALL QUESTIONS
24. YOU MAY NOW START TO USE THE SOFTWARE
25. TO VERIFY IF YOU RECEIVED THE COMPLETE UPDATE, ON THE DATE VERIFICATION SCREEN IN THE TOP RIGHT HAND CORNER, THE BUILD NUMBER WILL BE 98001.19
26. DO THE FOLLOWING STEPS AFTER 9-21-2000. DO NOT DO STEPS 27 - 42 BEFORE 09-21-2000 OR YOUR CLAIMS WILL REJECT
27. AT THE C:\MEDBDME PROMPT, TYPE EDIT DMERC.PRM
28. PRESS ENTER
29. USE YOUR ARROW KEYS AND ARROW OVER TWO SPACES
30. YOUR CURSOR WILL NOW BE UNDER THE 1
31. PRESS YOUR DELETE KEY 5 TIMES
32. NOW TYPE IN 00811
33. CLICK ON FILE
34. CLICK ON SAVE
35. CLICK ON EXIT

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36. YOU WILL NOW BE BACK AT THE MEDBDME

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
The bulletins are available at no cost from our website at www.umd.nycpic.com.

PROMPT
37. TYPE IN DME TO GET INTO THE SOFTWARE
38. PRESS ENTER ON THE DATE SCREEN
39. YOU WILL NOW BE ON THE SUBMITTER INFORMATION SCREEN
40. PUT IN THE PASSWORD
41. WHEN YOU PRESS ENTER YOU WILL RECEIVE AN ERROR MESSAGE AT THE BOTTOM OF THE SCREEN, THE SUBMITTER ID DOES NOT MATCH RECEIVER ID
42. CHANGE THE RECEIVER ID TO 00811
43. PRESS ENTER
44. YOU SHOULD NOW BE ON THE CLAIM ENTRY SCREEN

Important Announcement Regarding DMERC Transition

Supplier Notice 2000-28
September 21, 2000

To ensure a smooth transition of activities from United HealthCare to HealthNow, our office will be closed on Friday, September 22, and Monday, September 25. Walk in service and telephone services will not be available on those days. The office will reopen as HealthNow at the same location on Tuesday, September 26, at 8 a.m., at which time walk in service and telephone services will be available. Our telephone numbers and hours of operation will remain the same. We apologize for any inconvenience this may cause you.

Attention EDI Submitters

Supplier Notice 2000-29
September 29, 2000

Due to the DMERC transition, problems have been experienced with the production bulletin board. Corrective actions are underway.

Submitters may receive duplicate file rejects (XXX0100) for files submitted September 26 through September 29, 2000.

Be sure that you have a valid reject/acknowledgement report for your files submitted during this timeframe.

Please note that the production Bulletin Board System (BBS) will be down today until 3:30 PM for maintenance. Thank you for your patience.

Progressive Corrective Action Claim Review

Supplier Notice 2000-30
October 17, 2000

The Region A DMERC is expected to perform reviews of claims (pre-payment and post-payment) and to provide feedback to providers on issues identified. The DMERC is communicating this HCFA requirement to the suppliers in our region to encourage suppliers to comply with the requests for information, which you may receive from the Medical Review Department.

Medical Review will be requesting documentation to be submitted to the contractor within 30 days of request. Failure to submit the documentation requested may result in denials and/or overpayments. We strongly encourage suppliers to comply with these requests.

Breast Prosthesis

Supplier Notice 2000-32
November 2, 2000

Breast prostheses of all types are reimbursed under the prosthetic benefit. Certain guidelines apply to the provision of all prosthetic devices:

- Only one item is allowed at a time. Medicare does not pay for spare or "back-up" items. For those situations where there is a "left" and "right" side, one right and one left are reimbursed.

- Replacement is allowed when there is a change in the patient's medical condition sufficient to render the original prosthesis no longer useable or when the item has been irreparably damaged. In each case documentation describing the necessity for the replacement must be submitted with the claim.

Please refer to the Region A DMERC Supplier Manual and the medical policy for external breast prosthesis for additional information.

DMERC Supplier Manuals

The Region A DMERC provides one supplier manual free of charge to each new supplier who has received a new supplier number from the National Supplier Clearinghouse (NSC). The DMERC mails the manual to the mailing address the supplier has on file with the NSC approximately six to eight weeks after the DMERC receives notification from the NSC of the new supplier number.

Please note that the Region A DMERC does not provide back issues of the DMERC newsletters or supplier notices to new suppliers; these publications can be accessed on the DMERC website at www.umd.nycpic.com.

The DMERC charges a $50 fee to all suppliers who wish to receive an extra or replacement copy of the supplier manual. Companies or organizations that do not have a supplier number (i.e., billing clearinghouses, associations, etc.) are also charged a $50 fee for a copy of the supplier manual.

To order a copy of the Region A DMERC supplier manual, complete the form below and mail the form and a check for $50 made payable to HealthNow NY, Inc. to the address listed below.

- -

Company Name: ______________________________

NSC Number: ______________________________

Mailing Address: ______________________________

____

Contact Name: ______________________________

Telephone Number: ______________________________

Quantity: ______________ Amount Enclosed: ______________

Mail this form and payment in full (no cash) to:

HealthNow NY, Inc. DMERC A
P.O. Box 5251
Binghamton, NY 13902
Attn: Professional Relations

DMERC Medicare News

HealthNow NY, Inc. DMERC A ◆ P.O. Box 6800 ◆ Wilkes-Barre, PA 18773-6800

Suppliers: This newsletter should be directed to your billing manager.