DMERC
Medicare
News

DMERC Region A Service Office • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800 • Phone (570) 735-9445 • www.medicare-link.com
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Region A DMERC Y2K Millennium Rollover = Success!

The Region A DMERC - UHC is proud of its accomplishments during the millennium rollover. The degree of success attained was the outcome of great synergy created by all team members at HCFA, VIPS, UHC Home Office and Information Systems, the IGS Data Centers, the Field Office in Nanticoke, PA, the Program Integrity Unit in Meriden, CT, and the supplier community who participated in testing.

One of the greatest challenges was to ensure that all processing systems were "GO!" To that end, countless hours were devoted to renovating, upgrading, and successfully testing all hardware and software to ensure that claims with dates of service (DOS) 2000 would adjudicate correctly. HCFA had instructed all contractors to hold claims with dates of service 2000 until January 10, 2000 or January 17, 2000. The Region A DMERC received approval from HCFA to release claims with DOS 2000 on January 10, 2000, and claims are adjudicating appropriately.

Other Y2K challenges were mitigated by the development of numerous contingency plans to be invoked in the event that there were system or operational failures. Due to the dedication of all team players throughout the planning process, NO contingency plans were required to be invoked. This was another milestone achieved.

Telecommunications, vendor, and facility checkouts were conducted, all without incident.

THANKS TO ALL who worked diligently to ensure that customer service to our suppliers, beneficiaries, and HCFA was not impacted by Y2K!

In This Issue

Internet Address

Region A DMERC Office
www.medicare-link.com

HCFA Office
www.hcfa.gov

Don't miss out – get your supplier notices and alerts via email

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

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

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

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins issued after October 1, 1999 are available at no cost from our website at www.medicare-link.com.

Billing

Home Glucose Reminder

Claims that are submitted to the DMERC for home glucose supplies and accessories such as monitors, strips, lancets, and solution must have the proper ICD-9-CM diagnosis code and HCPCS modifiers included. Claims submitted without the proper ICD-9-CM diagnosis code for these supplies will be denied as not medically necessary. Claims submitted without the proper HCPCS modifier (refer to Chapter 14.6 of the *Region A DMERC Supplier Manual)* will be denied as submission / billing error.

Milrinone

Milrinone (J2260) is an intravenous inotropic drug used in an infusion pump. The full code narrative is: Injection, milrinone lactate, per 5 ml. The code descriptor was established based on the fact that the drug was originally supplied in vials with 5 mg of milrinone in 5 ml of solution. When suppliers submit claims for code J2260, they must report 1 unit of service = 5 mg of milrinone, regardless of the volume of solution in which it is dispensed. This is a clarification.

Reminder – Block 29 of the HCFA-1500 Form

Attention: Suppliers! Only the total amount the beneficiary paid for covered services should be entered into Block 29 of the HCFA-1500 form. Do not report the primary insurance payment in Block 29. Entering inappropriate information in this field will result in incorrect processing of your claim. *Please refer to Chapter 3 and Chapter 7 of your Region A DMERC Supplier Manual for more information on completing the HCFA 1500 form.*

EDI

Thank You for Y2K Testing

Here we are in the year 2000! We made it without any major systems mishaps; claims are being submitted as usual, and electronic billing is working without interruption. This smooth transition, however, did not happen all by itself. In the past year, United HealthCare employees spent thousands of hours performing internal testing and proactive supplier education; Health Care Financing Administration (HCFA) employees made helpful recommendations concerning testing and assisted us in contacting many vendors directly to encourage system testing. You, our vendors, clearinghouses, and submitters, responded to our call. Thirteen hundred submitters participated in Y2K testing. Although this testing did not certify your system for Y2K compliance, it demonstrated what would happen with claims created by your billing system and submitted in the year 2000.

Thank you for your enthusiasm and your cooperation. We trust that 2000 will continue to be a year for meeting new challenges in electronic billing in a manner that is beneficial and rewarding for all of us.

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National Standard Format (NSF) for Electronic Remittance Notice

Effective April 1, 2000

Several updates to all versions of the NSF ERN format become effective on April 1, 2000. Explanatory remarks were added to each amount field to clarify how each amount is to be calculated, thus eliminating possible confusion. Remarks were also added to clarify which fields are used in the balancing of payment information with NSF ERN transactions. The word "should" was replaced with "must" in most cases to clarify expectations for use of certain fields.

An updated edition of the NSF ERN version 2.01 is now available for downloading under title 2.01U from the HCFA Electronic Data Interchange (EDI) web site: www.hcfa.gov/medicare/edi/edi.htm. The new edition is also located on the United HealthCare Medicare's web site: www.medicare-link.com.

Version NSF 2.01

These clarifications and calculation adjustments apply to the corresponding fields in each version of the NSF ERA: 2.01, 2.00, and 1.04.

100-04 Requirement corrected from "O" to "R."

100-06 Requirement corrected from "O" to "R."

200-06 "Should" has been replaced by "must" in the validation.

200-10 "Should" has been replaced by "must" in the remark.

450-04 "Should" has been replaced by "must" in the remark.

450-10 Clarified that this filler is reserved for national use. Requirement corrected to "R."

450-11 Place of service 60, mass immunization center, added to the list of valid codes.

450-12 "Type of service" code is no longer required; this is established by HCPCS. This field has been converted to filler reserved for national use. Requirement changed to "R."

450-18 Remark added "Total of all charges for the procedure billed on this line. Used in balancing."

450-19 Remark added that not used to balance for Medicare.

450-20 Remark added that not used to balance for Medicare.

450-21 Remark added that used in balancing.

450-22 Remark added that used in balancing.

450-23 Remark added that used in balancing.

450-24 Remark added that not used to balance for Medicare.

450-25 Remark added that not required for Medicare nor used to balance for Medicare.

450-26 Remark added that required for Medicare when applicable, used to balance, and entry must correspond to amount on the Medicare Summary Notice (MSN).

450-27 Remark added that not used to balance for Medicare.

450-28 Remark added correcting prior calculation formula for this field and clarifying that it is used in balancing. This is the computed sum of Submitted Line charges (450-18) less: Deductible amount (450-22) Coinsurance (450-23) Amount paid by other payor (450-26) Actual payment to payee (450-33) Dollar Amounts 1-5 (451-10 – 14) Dollar amounts 6-7 (451-22 – 23).

450-29 Remark added that not used to balance for Medicare.

450-30 Remark added that not used to balance for Medicare. May be reported for informational purposes only.

450-31 Remark added that not used to balance for Medicare.

450-32 Remark added that not used to balance for Medicare. May be reported for informational purposes only.

450-33 Remark added that used in balancing.

450-38 Remark added to identify web site where all approved claim adjustment reason codes are maintained. www.wpc-edi.com

451-03 "Should" replaced by "must" in the remark.

451-04 "Should" replaced by "must" in the remark.

451-07 Remark added that not used to balance for Medicare, but must be reported for informational purposes if it applies.

451-10 Remark added that adjustments for which a dedicated reporting field exists must not be repeated in a miscellaneous adjustment field, and used for balancing.

451-16 Remark added that remark codes must be used where applicable.

451-22 Remark added that adjustments for which a dedicated reporting field exists must not be repeated in a miscellaneous adjustment field, and used for balancing.

451-23 Remark added that adjustments for which a dedicated reporting field exists must not be repeated in a miscellaneous adjustment field, and used for balancing.

451-24 Remark added that not used to balance for Medicare.

500-05 Remark added that used in balancing.

500-06 Remark added that not used to balance for Medicare.

500-07 Remark added that not used to balance for Medicare.

500-08 Remark added that not used to balance for Medicare.

500-09 Remark added that not used to balance for Medicare.

500-10 Remark added that not used to balance for Medicare.

500-11 Remark added that not used to balance for Medicare, but must be reported for informational purposes if it applies.

500-12 Remark added that used in balancing.

500-13 Remark added that where this applies, it must be reported at the service level and not at the claim level.

500-14 Remark added that not used to balance for Medicare.

500-15 Remark added correcting the prior calculation formula for this field and clarifying that it is used in balancing. This is the computed sum of Claim submitted charge*s (500-05) less: Deductible amount (450-22) Coinsurance (450-23) Amount paid by other payor (450-26) Actual payment to payee (450-33) Dollar Amounts 1-5 (451-10 – 14) Dollar amounts 6-7 (451-22 – 23) CT Gramm Rudman Reduction (500-12) CT previous Pay to provider (500-17) CT previous pay to payee (500-18) Dollar amounts 1-3 (500-33 – 35).

500-16 Remark added that not used to balance for Medicare.

500-17 Remark added that used in balancing and equivalent to OA B13 entries in an 835.

500-18 Remark added that used in balancing.

500-19 Remark added that it may be reported for informational purposes, but is not used to balance for Medicare.

500-20 Remark added that it may be reported for informational purposes, but is not used to balance for Medicare.

500-22 Remark added that it is not used to balance for Medicare.

500-23 Remark added that it is not used to balance for Medicare.

500-26 Term "PayerID" replaced by "PlanID."

500-28 Term "PayerID" replaced by "PlanID."

500-30 Remark added to identify web site, www.wpc-edi.com, where all approved claim adjustment reason codes are maintained, and to clarify that at least one reason code must be reported at the claim level. Requirement for -30 corrected to "R."

500-33 Remark added that if applicable, required for Medicare, and used in balancing.

700-07 Remarks added that used in balancing, not permissible to repeat any adjustment at the provider level already reported at the line or claim level, and requiring reporting of any type of interest at the provider level for balancing purposes.

700-08 Example of financial control number added to the definition.

800-09 Remark added that not required for Medicare.

800-10 Remark added that not required for Medicare.

800-14 Calculation remark, total of all 500-11 entries, added. Definition amended to specify that the interest referred to is claims processing timeliness interest.

800-15 Calculation remark, total of all 500-12 entries, added.

800-16 Calculation remark, total of all 450-26 entries, added.

800-17 Calculation remark, total of all 700-07 entries, added.

800-18 Calculation remark, total of all 500-15 entries, added.

800-19 Remark added that not required for Medicare.

800-20 Calculation remark, total of all 500-17 entries, added.

800-21 Calculation remark, total of all 500-18 entries, added.

800-22 Clarifications added for the use of AJ and OF provider adjustment codes in the calculation of this field.

800-23 Calculation remark, total of all 500-20 entries, added.

800-26 Clarification added, unused record space reserved for national use.

800-28 Calculation remark, total of all 700-07 entries, added.

800-29 Calculation remark, total of all 500-29 entries, added.

900-10 Remark added that not required for Medicare.

900-11 Remark added that not required for Medicare.

900-12 Calculation remark, total of all 800-11 entries, added.

900-13 Calculation remark, total of all 800-12 entries, added.

900-14 Calculation remark, total of all 800-13 entries, added.

900-15 Calculation remark, total of all 800-14 entries, added. Definition amended to specify that the interest referred to is claims processing timeliness interest.

900-16 Calculation remark, total of all 800-15 entries, added.

900-17 Calculation remark, total of all 800-16 entries, added.

900-18 Calculation remark, total of all 800-17 entries, added.

900-19 Calculation remark, total of all 800-18 entries, added.

900-20 Remark added that not required for Medicare.

900-21 Calculation remark, total of all 800-20 entries, added.

900-22 Calculation remark, total of all 800-21 entries, added.

900-23 Calculation remark, total of all 800-22 entries, added.

900-24 Calculation remark, total of all 800-23 entries, added.

900-25 Calculation remark, total of all 800-24 entries, added.

900-26 Calculation remark, total of all 800-25 entries, added.

900-27 Calculation remark, total of all 800-29 entries, added.

900-28 Clarification added, unused record space reserved for national use.

Improving Bulletin Board Communications

The United HealthCare Medicare offices continue to strive to identify ways to improve your transmission uploads and downloads to/from the Bulletin Board Systems. By simply increasing the baud rate of your modem or changing your transfer protocol, you will decrease your connect time to our system. By reducing your connect time you will ultimately save money on your long distance calls to Medicare. Please contact your vendor today and inquire about your baud rate and transfer protocol.

To use our existing equipment more efficiently, Medicare will restrict file transfer of data at 1200 baud rate until non-peak hours. The hours for transferring data with a 1200 baud rate will be after the 1:00 P.M. upload. In the near future, Medicare will restrict use of the 2400 baud rate modem.

Listed below are several suggestions for improving your transmissions.

Tips for Improving Transmission Times

- Increase your modem speeds. At Medicare, our modems are 28.8/33.6 KBPS.
- Use Zmodem as your first choice of transfer protocol. Eliminate the use of Xmodem transfer protocol. Xmodem is inefficient and originally designed to work with slower modems such as 1200 and 2400 baud rates.
- If you currently use Kermit protocol, use SuperKermit to make your transfer more efficient.
- Zipping a file reduces the size by nearly 90%. Medicare supports PKzip (version 2.04G). Contact your local Medicare carrier prior to transmitting a zipped file.

The following table compares upload times for the same file using common protocols. The file used for the test was about 2MB (approximately 980 claims).

Protocol	**Upload times in minutes**
Zmodem	6
Ymodem Batch	18
Xmodem	26
Zipped file with Zmodem	Less than 1 minute

HIPAA Web Sites

The following web sites contain information on HIPAA or HIPAA-related topics:

Stay in touch with Health Insurance Portability & Accountability Act (HIPAA) health information security issues and developments as they evolve. Subscribe to HIPAAlert, a free monthly email newsletter for health care managers who must address HIPAA compliance issues and requirements. Sign up for your free subscription by clicking:

http://hipaalert.com

and receive our next issue at the end of the month. In the meantime, you will have web access to all past issues of HIPAAlert and HIPAAlert NewsBriefs.

HIPAAlert newsletter now has a "sister" discussion list: HIPAAlive

To join the HIPAAlive discussion group, go to the hipaalert.com site and click on the HIPAAlive icon.

Also from the hipaalert.com site, there are links to various web sites that are HIPAA related:

- Department of Health and Human Services (DHHS)
- Health Care Financing Administration (HCFA)
- The Workgroup for Electronic Data Interchange (WEDI) is a broad-based industry association, which was designated by HIPAA as an advisor to the Secretary of DHHS regarding EDI standards.
- The Joint Healthcare Technology Alliance
- The American Medical Association's American Medical News site (AMA)
- The National Committee on Vital and Health Statistics (NCVHS)

Health Hippo is a collection of policy and regulatory materials related to health care

http://hippo.findlaw.com/

Data Interchange Standards Association (DISA)

http://www.disa.org

Washington Publishing (Implementation Guide publisher)

http://www.wpc-edi.com

Health Level 7 (HL-7)

http://www.hl7.org

HCPCS

Oral Anticancer Drugs – Busulfan and Temozolomide

Coverage of oral anticancer drugs has been expanded to include two additional drugs.

Coverage of oral busulfan (Myleran) is effective for dates of service on or after August 1, 1999. The NDC code for oral busulfan is:

00173-0713-25 Busulfan, 2 mg, oral

Coverage for oral temozolomide (Temodar) is effective for dates of service on or after November 1, 1999. The NDC codes for temozolomide are:

00085-1248-01 Temozolomide, 5 mg, oral

00085-1248-02 Temozolomide, 5 mg, oral

00085-1244-01 Temozolomide, 20 mg, oral

00085-1244-02 Temozolomide, 20 mg, oral

00085-1259-01 Temozolomide, 100 mg, oral

00085-1259-02 Temozolomide, 100 mg, oral

00085-1252-01 Temozolomide, 250 mg, oral

00085-1252-02 Temozolomide, 250 mg, oral

Until the DMERC publishes notification that the NDC codes may be used, claims for these two drugs must be submitted using code J8999 (Prescription drug, oral, chemotherapeutic, not otherwise specified). Include the name of the drug, the NDC code, and the number dispensed in the HA0 record of an electronic claim or attached to a hard copy claim.

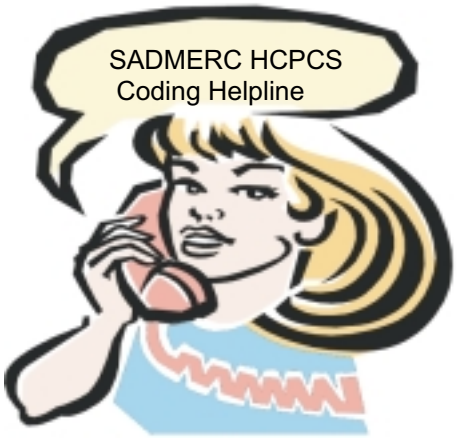
Refer to the DMERC medical policy on Oral Anticancer Drugs for additional information on coverage, coding, and documentation.

Sirolimus (Rapamune), New Immunosuppressive Drug Coverage

It has been determined that sirolimus, trade name Rapamune, is eligible for Medicare reimbursement under the immunosuppressive drug benefit. Until a unique code is granted, this drug should be coded using HCPCS code J7599 (Immunosuppressive drug, not otherwise classified). When using this code, the name of the drug, dosage strength, number dispensed, and administration instructions must be included on the claim. All of the requirements for eligibility and length of the benefit apply as outlined in the medical policy for "Immunosuppressive Drugs" *Region A DMERC Supplier Manual.* This decision is effective for claims with dates of service on or after September 15, 1999.

SADMERC HCPCS Coding Helpline

(803) 736-6809
9:00 A.M. – 4:00 P.M. (Monday, Tuesday, Thursday, and Friday)
9:00 A.M. – 6:00 P.M. (Wednesday)



This article was submitted by the SADMERC. Any questions regarding this article should be directed to the SADMERC.

The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) is responsible for the coordination of all HCPCS coding activities for durable medical equipment, prosthetics, orthotics and supplies for Medicare. The SADMERC operates a HCPCS coding helpline, responds to written inquires, and assists with new and existing code requests.

The SADMERC can:

- Assist with HCPCS coding determinations
- Give allowables that are on the Fee Schedule
- Assist with requests for HCPCS Coding Verifications
- Assist with requests for New Level II Temporary HCPCS Codes

The SADMERC cannot:

(If suppliers have questions regarding the following subjects, please contact your DMERC.)

- Provide codes for items that are not billable to the DMERCs
- Answer coverage or policy questions
- Address claims inquiries
- Provide a beneficiary's eligibility
- Assist with claim forms
- Address required documentation for claims
- Provide allowables for items priced by reasonable charge
- Provide allowables for individually considered items
- Provide publications such as the Supplier Manual, newsletters, or Fee Schedule
- Address CMN information
- Assist with Type of Service or Place of Service

The SADMERC and the four Durable Medical Equipment Regional Carriers (DMERCs) conduct reviews of products to determine the correct HCPCS codes for Medicare billing. The SADMERC completes a review of the product and forwards the information to the four DMERCs for review. SADMERC coordinates the review and responds to the requestor in writing with the final decision. The SADMERC asks that you allow 90 days for the completion of the review. When submitting product literature for review, please refer to the following article "Required Documentation Necessary for HCPCS Coding Verifications."

Written inquires may be directed to the SADMERC at the following address:

SADMERC
Post Office Box 100143
Columbia, SC 29202-3143

Required Documentation Necessary for HCPCS Coding Verifications

Please note that all HCPCS coding verifications require 5 (five) sets of all the following information. All information should be mailed to the SADMERC.

- Include wholesale and suggested retail cost of each item to be reviewed.
- List the monthly / weekly / daily rental charges for the item, if applicable.
- Send documentation of the FDA's current classification of the item. Minimum requirements include a copy of form FDA-2892 and either form FDA-2891 or FDA-2891a. Additional documentation is required for Class III and certain Class II devices.
- Provide the date that the item was available on the US market.
- Include color pictures of the item and current marketing literature (originals only, no photocopies).
- State the HCPCS code you feel best meets the description of your product.
- List all Universal Product Codes (UPC) or Universal Product Numbers (UPN) for each product to be reviewed.
- List all components and accessories included in the base price.
- Indicate whether you are the manufacturer, a distributor, or a supplier.

In addition to the information listed above, please include 5 (five) sets of the items listed below in the category that best describes your product.

Support Surfaces/Seating Cushions

- Provide a detailed description and exact dimensions of the product. This should include the height, depth, and width of all components, and the combined total of all components. Include engineering drawings of all components and the completed product.
- Include a description of how the product functions and the indications for use of this product.
- Provide pictures of the product without a cover.
- The manufacturer must permanently label samples of gel overlays and seating cushions submitted for review. Minimum labeling must include brand name and model number, as applicable, and contents of the product as the product will be marketed.
- Send warranty information for all parts and accessories of the product.
- Include user manuals for the product.
- All requests for Group 2 support surfaces must include documentation to substantiate that the product is effective for treatment of conditions described in the coverage criteria.

Surgical Dressings

- Include an exact description and sizes of all layers and component parts of the dressing.
- Include the exact amounts of each ingredient for each component of the product and percent of each chemical.
- List all sizes in which the dressing is available.

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- List all indications for use of your product (for multiple layer dressings, include indications and purposes of each layer or component of the dressing).
- Include 5 (five) samples of each dressing size.

Medications and Enteral or Parenteral Nutrition Products

- Provide the generic name of all drugs and pharmaceutical items.
- Provide the following for all pharmaceutical items: manufacturer's name, NDC number, indications, actions, dosage, side effects, administration recommendations, and how it is supplied.
- List all ingredients, and portions of each, for all enteral and parenteral products.
- List and describe similarities to other enteral or parenteral products on the market.
- Include product labels for all enteral and parenteral products.

Orthotics and Prosthetics

- Provide an exact description, including how it is made and the materials from which each component is made.
- Include a description of where on the body the device or item is to be worn or used.
- List the indications for use of the item and how the patient is taught to apply.
- For products with several components, include a full picture of each component unobstructed and an explanation of how it is attached to the product.

Durable Medical Equipment and Medical Supplies

- Provide an exact description of the item. Include all component parts and/or accessories.
- Provide a description of how this equipment operates and functions.
- List of all supplies necessary for the use and operation of the equipment.
- List the indications for use of the equipment.
- Send operations and patient instruction manuals.
- Send warranty information for the equipment and component parts.
- Provide the recommended duration of use for all supplies associated with the equipment.
- Include results of clinical studies that have been performed using this equipment.

Due to the complexities of some products, further information, not listed above, may be required, upon request.

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Hearing and Review

Helpful Hints for Filing Reviews

To ensure that your requests for review of an initial claim determination can be handled promptly and accurately, keep these helpful hints in mind:

- Be specific in your review request. Provide the beneficiary's name, Health Insurance Claim (HIC) number, and the date of service. To identify the specific claim being requested for review, provide the Internal Control Number (ICN) assigned to the initial claim. Additionally, remember to include surgery dates, equipment pick-up and/or delivery dates, specific make and model numbers of equipment, and the purpose or use of certified equipment or supplies where appropriate. For complete instructions refer to Section 8.1, pages 8.1 - 8.6 of the *Region A DMERC Supplier Manual.*
- When requesting a review of an initial claim determination involving a Certificate of Medical Necessity (CMN), be sure all required fields are completed, i.e.: **initial/revised/ recertification date as appropriate**, all questions on the CMN have been answered; the CMN includes the physician's address, as well as the physician's signature; and the date the CMN was signed. Any additional documentation to support the need for equipment and/or supplies should be included with your review request. Also, the supplier's National Supplier Clearinghouse (NSC) number and the Unique Physician Identification Number (UPIN) should be documented on the Certificate of Medical Necessity as well as on the initial claim form. Refer to Section 12.7, pp. 49 - 64 of the *Region A DMERC Supplier Manual.*
- When including Medicare Remittance Notices or Electronic Remittance Notices as part of your request for review, be sure to highlight or circle the beneficiaries for whom the review is being requested.
- Ensure that all handwritten requests for review are legible.
- When faxing requests for review, ensure that all pages are transmitted successfully. Be sure to use the appropriate fax number, which is 570-735-9599. Please note that there is a six-page fax limit on fax transmissions.

  Refer to: Supplier Notice 98-24 "DMERC Communication Suggestions."
- The Region A DMERC had accepted medical necessity denials as adjustments in certain situations. However, these denials must be submitted as reviews in order to be consistent with the appeals process. This process ensures compliance with providing adequate documentation with the review request. Please refer to Supplier Notice 99-36 published on page 20 of this newsletter.

Please note: Additional information (shown in bold print) has been added to this previously published article.

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Medical Policy

Immunosuppressive Drug Policy Update

In the accompanying *Region A DMERC Supplier Manual* update is a revision of the Immunosuppressive Drugs Regional Medical Review Policy. This policy revision incorporates new HCPCS codes which are effective April 1, 2000. It also includes the details of the immunosuppressive drug benefit extension (see table below) found in the Balanced Budget Refinement Act of 1999. The benefit extension is effective for dates of service on or after January 1, 2000, and affects beneficiaries whose benefit would otherwise be expiring in the years 2000 through 2004.

Discharge Date After Covered Transplant Surgery	**Drug Benefit Period**
July 1, 1995 - December 31, 1996	Limited to 36 months from date of discharge
January 1, 1997 - December 31, 1997	Extended to 44 months from date of discharge
On or after January 1, 1998	At least 36 months from date of discharge, with an additional number of months to be determined

For patients discharged on or after January 1, 1998, the exact length of coverage will be determined at a later date by the Health Care Financing Administration (HCFA) in accordance with statutory guidelines. The new limits of coverage will be published by the DMERC when announced by HCFA.

Osteogenesis Stimulators

A revision of the Osteogenesis Stimulators policy is included in the accompanying *Region A DMERC Supplier Manual* update. The major change in the policy is a revision of the definition of nonunion of a long bone fracture which is one of the conditions for which a nonspinal electrical osteogenesis stimulator (E0747) is covered. This is the result of a change in the national policy in the *Medicare Coverage Issues Manual*, section 35-48. The revised policy is effective for claims with dates of service on or after April 1, 2000. The policy also clarifies the bones that are considered long bones.

Until such time as the wording of question 6a on the Osteogenesis Stimulators CMN can be revised to more clearly describe the new definition of a fracture nonunion, with each CMN that it is sent to a physician, the supplier must attach the following statement:

> "For purposes of answering question #6a on the attached Certificate of Medical Necessity (CMN), a fracture nonunion is considered to exist only when a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days and each including multiple views of the fracture site, have been interpreted by a physician in writing as showing that there has been no evidence of fracture healing between the two sets of radiographs. If this definition of nonunion is not met, question 6a must be answered No."

External Infusion Pump Policy Update

In the accompanying *Region A DMERC Supplier Manual* update is a revision of the External Infusion Pump Regional Medical Review Policy (RMRP). This policy revision incorporates new HCPCS codes that became effective January 1, 2000. In addition, the coverage criteria for liposomal amphotericin B were corrected to consider coverage in patients with impaired *renal* function rather than impaired *hepatic* function.

The RMRP also includes new coverage criteria for external insulin infusion pumps (HCPCS code E0784) as a result of a revised national coverage determination for §60-14 of the *Coverage Issues Manual*. As outlined in the RMRP, external insulin infusion pumps and supplies are covered for type 1 diabetics (only) who meet Medicare coverage criteria. An ICD-9-CM diagnosis code specific to the 5th digit (e.g., 250.11), describing the condition which necessitates the insulin pump, must be included on all claims for insulin pumps, insulin and/or supplies. Submission of a claim lacking a covered ICD-9-CM diagnosis code will result in a denial for medical necessity. Alternatively, failure to provide an ICD-9-CM diagnosis code on the claim will result in rejection of the claim for missing information.

Supplies for the insulin pump should be billed using codes A4221 and code A4232. Insulin for use in the pump is billed using code J1820. Codes A4230 (infusion set for external insulin pump, non needle cannula type) and A4231 (infusion set for external insulin pump, needle type) are not valid for claim submission to the DMERC because they are included in code A4221.

This policy revision is effective for dates of service on or after April 1, 2000. Please refer to the External Infusion Pump Regional Medical Review Policy in the *Region A DMERC Supplier Manual* for further details on the coverage and payment rules, coding guidelines, and documentation requirements.

Nebulizer Drugs – Documentation

The Region A Regional Medical Review Policy for Nebulizers requires that claims for amounts of nebulizer drugs exceeding the usual guidelines outlined in the policy be accompanied by additional documentation to justify medical necessity.

The Nebulizer Policy requires the following documentation when billing for additional amounts of nebulizer drugs:

- "copy of the prescription(s)"
  and
- "physician narrative documentation supporting the medical necessity for the higher utilization"

Region A has noted that the physician's narrative can be vague and does not address the specific need for that patient. In these cases, suppliers should consider sending in the following documentation to substantiate the use of nebulizer drugs in amounts over the suggested guidelines in the Nebulizer Policy:

- A copy of the prescription that is signed and dated by the treating physician describing the name of the drug, strength, frequency of use. "PRN" as a frequency parameter is not acceptable and will result in denial of the claim.
- Progress notes documenting the failure of therapy at the usual suggested doses.
- Signs, symptoms, and severity of the beneficiary's lung condition.
- Alternative therapies and/or medications tried and the results.

Please refer to the Nebulizer Policy in the *Region A DMERC Supplier Manual* for further details on coverage, coding, and documentation requirements.

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins issued after October 1, 1999 are available at no cost from our website at www.medicare-link.com.

Ostomy Supplies

Please remember to maintain on file the following information when billing for ostomy supplies with claims for dates of service on or after January 1, 1997.

The following information includes:

- An order for the ostomy supplies which has been signed and dated by the treating physician. The order must include the type of supplies ordered and the approximate quantity to be used per unit of time. An ICD-9-CM diagnosis code describing the type of ostomy (V44.2, V44.3, V44.6, V55.2, V55.3, or V55.6) should be included on the initial order to a supplier. A new order is required if there was a change in the quantity of the supply used per unit and/or the type of supply used.

- The need for a greater quantity of supplies than the amount listed must be well documented, and this documentation may be requested by the DMERC. Please refer to the Usual Maximum Quantity of Supplies table in the Ostomy Supplies policy, Chapter 16.10 in the *Region A DMERC Supplier Manual*. If the DMERC requests justification for the quantity of supplies billed, the information submitted should include the quantity of the supply to be used per unit of time and an explanation of why the patient requires more supplies than usual.

For more information, please refer to the *Region A DMERC Supplier Manual*, Chapter 16.10.

Oxygen CMN – Revision

The Office of Management and Budget (OMB) has mandated a revision of the Oxygen Certificate of Medical Necessity, HCFA Form 484. The changes on the back of the form are as follows: a change in the estimate of the time needed to collect the information, a HCFA address change, and substitution of the term "treating physician" for "ordering physician." There are no changes to the front of the CMN except that the date of the form (found in the lower left corner) has been changed from 5/97 to 11/99. This revised CMN is still designated DMERC Form 484.2. The revised DMERC 484.2 (11/99) may be used for oxygen claims received on or after April 1, 2000 and is required for all oxygen CMNs received on or after October 1, 2000. The current Form 484.2 (5/97) may continue to be used for claims received on or before September 30, 2000; however, it will be invalid for all oxygen CMNs received on or after October 1, 2000.

A revision of the form is published in the Medical Policy section of the accompanying *Region A DMERC Supplier Manual* update. The revised form is also available on the Region A DMERC web site, www.medicare-link.com.

Urological Supplies Policy Revision

In the December 1999 *Region A DMERC Supplier Manual* update, verbiage was inadvertently omitted from the Urological Supplies Regional Medical Review Policy (RMRP) revision. The italicized verbiage below was present in previous versions of the policy but was absent in the latest revision published. Coverage and Payment Rules for Indwelling Catheters (p. 16.9-5 – 16.9-6), indications #3 and 4 for non-routine changes should read:

3. Catheter is obstructed by encrustation, mucous plug, *or blood clot.*

4. History of recurrent obstruction or *urinary tract* infection for which it has been established that an acute event is prevented by a scheduled change at intervals of less than one per month.

We are republishing this information with the corrected verbiage with this update of the *Region A DMERC Supplier Manual.*

The RMRP also reflects updates to the Coding Guidelines (p. 16.9-11 – 16.9-12) which clarify the previously published payment policy for HCPCS code A5200 (Percutaneous catheter/tube anchoring device, adhesive skin attachment). (See *DMERC Medicare News*, December 1998, p. 11.)

Miscellaneous

Updates from the National Supplier Clearinghouse

New Supplier Standards

HCFA's final rule has been sent to the Department of Health and Human Services. They will then travel to the OMB (Office of Management and Budget). Once approved by both offices, the 20 supplier standards will be published. The new standards will be effective 60 days from that date. We are still anticipating/hoping that they will be out in this first quarter of 2000.

Surety Bond

We still hear October 1, 2000. We think it will be $50,000 bond per TIN. We will keep everyone posted as we hear.

NSC Web site

Be sure to visit our web site. There is a lot of good information out there, though we are hard to find. Our address is: www.pgba.com (under "Other Medicare Partners"). Some of the resources located within our site are:

1. Electronic HCFA 855S Application (you cannot SUBMIT electronically, but it's easier to use in that you can enter information and print the application)
2. Frequently Asked Questions have been updated. Lots of useful information there.
3. NSC News newsletter under "Hot Topics" (Fall 1999 and soon to be published Winter 2000 (February 2000))

New HCFA 855S Application

NSC has been working on a new, revised version of the HCFA 855S application, which should be MUCH easier to use, as the people who wrote the application and

the instructions were in the same room this go around. We have also had some people in the field who USE this application to give their input. We think everyone will like it.

It has been sent to HCFA Central Office, and we are waiting for their comments. We do fear that the application is being held up due to the fact that HCFA is in the process of reviewing the 855 form; however, now that the Y2K bug is dead, we're hoping that it'll speed up soon. We are still hoping for a spring implementation.

Change of Information

One of the toughest tasks we have here at the NSC is getting suppliers to let us know when their information has changed! Unless it affects suppliers receiving their money, suppliers seem reluctant to notify us of information changes. Some examples of such changes are:

- Address and/or phone
- Ownership or Owner
- Insurance/Licensure

Suppliers have 30 days to notify the NSC of any change of information. Do not wait until you re-enroll to let us know. Even if you are in the process of re-enrolling, it is recommend that you send your change information in as a correspondence (in writing on letterhead paper with authorized representative signature). NSC does not accept faxed notifications. Please include your supplier number on the correspondence (so we can link it up here in-house with your file).

Re-Enrollments

Do not forget that for re-enrollments you must fully complete the HCFA 855S Application form. You cannot only make updates on the computer-generated form.

(Submitted by Natalie Castro, Supplier Relations Specialist, National Supplier Clearinghouse. Please contact the NSC for any questions regarding information contained in this article.)

Appeals Analysis Program

United HealthCare has reintroduced an Appeals Analysis Program (AAP) for all DMEPOS claims. Each quarter, the top 10 HCPCS codes that are initially denied but paid upon review will be identified. The reason for the initial denial can then be determined as one of three causes: a processing error, a system programming error, or a supplier submission error.

Once identified, the appropriate action will be taken to resolve the problem, thus eliminating unnecessary reviews. Processing errors or system problems will be swiftly addressed by the Region A DMERC. In situations where claims were submitted incorrectly, the Region A DMERC will identify the problem and provide the supplier with the proper steps to avoid unnecessary reviews in the future.

By instituting the use of the AAP, the Region A DMERC can significantly decrease the number of claims that unnecessarily go through the review process. Suppliers will receive prompt payment, when appropriate, and eliminate wasted time and effort associated with the review process.

If you are identified as a supplier that falls under AAP consideration, you will be contacted by the appropriate Ombudsman in the Professional Relations Unit to identify the particular HCPCS code and the appropriate action to take.

Professional Relations

Professional Relations Announcement

Effective January 21, 2000, Kevin Quaglia is no longer serving as the Respiratory Ombudsman for the Region A DMERC. Respiratory Ombudsman issues will be forwarded to David Fiorini, the Secondary Ombudsman for the Respiratory product category, until this position is filled.

Rehab Subcommittee Established

The Professional Relations Unit, along with members of the Region A Council, recently joined together to form a Rehab Subcommittee. The key focus of the Subcommittee is to work together on issues relative to wheelchair claims. The first conference call was held on December 7, 1999. Subsequent quarterly meetings will follow.

Supplier Notice

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

Y2K Testing Reminder

Supplier Notice 99-35
November 10, 1999

Attention providers submitting Y2K test claims: please remember to submit your test claims only to the test Bulletin Board System (BBS) at the following number: 203-639-3389

Medical Necessity Denials

Supplier Notice 99-36
November 15, 1999

The Region A DMERC had accepted medical necessity denials as adjustments in certain situations. However, these denials must be submitted as reviews in order to be consistent with the appeals process. This process ensures compliance with providing adequate documentation with the formal review request.

For more information on filing reviews, please refer to the "Helpful Hints for Filing Reviews" article published in the September 1999 edition of the *DMERC Medicare News.*

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins issued after October 1, 1999 are available at no cost from our website at www.medicare-link.com.

Electronic Fund Transfer Enrollment

Supplier Notice 99-37
November 15, 1999

In order to minimize the risk of impact from the Year 2000, we will not set-up any suppliers for EFT during the month of December. Although we have thoroughly tested our programs, there is no way to ascertain that all suppliers' banks have done the same. Terminations and updates to bank account types will be allowed for existing EFT suppliers.

If you are considering enrolling in EFT, you must do so prior to December 1st or postpone enrollment until the new year.

Correction to September 1999 Article

Supplier Notice 99-38
November 24, 1999

The article "Adoption of Standard Electronic Health Care Transaction Formats in the United States" published on pages 23 – 25 of the September 1999 edition of *DMERC Medicare News* contained an incorrect internet address on page 25.

The third internet address on page 25 has been corrected to:
http://aspe.os.dhhs.gov/admnsimp

The corrected article will be reprinted in its entirety in the December 1999 edition of *DMERC Medicare News*.

We apologize for any inconvenience this may have caused.

Enteral/Parenteral Claims

Supplier Notice 99-39
December 14, 1999

All initial claims for enteral/parenteral nutrition MUST be submitted with a completed Certificate of Medical Necessity (CMN), as required by policy, for proper claims adjudication. Additionally, for revisions or recertifications, the CMN MUST accompany the claim. This requirement includes enteral/parenteral claims for items billed with a ZY modifier "for denial only." Failure to submit the required CMN will result in a denial of the claim.

Please consult the Documentation section(s) in Chapter 18 of the *Region A DMERC Supplier Manual* for additional information on the CMN requirements for enteral/parenteral nutrition claims.

2000 Ceiling Fees for Therapeutic Shoes

Supplier Notice 99-40
December 28, 1999

Listed below is the 2000 Special Limitation for Therapeutic Shoes under the Standard Reasonable Charge Rules. These limits apply to codes A5500 – A5506. Reasonable charge fees are established for each state. However, the maximum allowable amount for each code cannot exceed the ceiling amount. The current ceiling breakdown for 2000, which is the same for all states, is as follows:

Code	Ceiling
A5500	$63.00
A5501	$189.00
A5502	$32.00
A5503	$32.00
A5504	$32.00
A5505	$32.00
A5506	$32.00

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins issued after October 1, 1999 are available at no cost from our website at www.medicare-link.com.

Correction to 2000 Fee Schedule

Supplier Notice 99-41
December 29, 1999

In the 2000 Region A DMERC Fee Schedule, the fees for *Supplies* and some of the fees for *Surgical Dressings* were listed under the incorrect category headings (pages 6-79 – 6-81). Attached is a list of these fees listed under their correct category heading. We apologize for any confusion this error may have caused.

Supplies

HCPCS	Mod	Ceiling	Floor	CT	DE	MA	ME	NH	NJ	NY	PA	RI	VT
A4221		$21.59	$18.35	$21.59	$21.59	$21.59	$21.59	$21.59	$21.59	$21.59	$21.59	$21.59	$21.59
A4222		$44.57	$37.88	$44.57	$44.57	$44.57	$44.57	$44.57	$44.57	$44.57	$44.57	$44.57	$44.57
A4255		$3.92	$3.33	$3.73	$3.73	$3.73	$3.73	$3.73	$3.73	$3.73	$3.73	$3.73	$3.73
A4256		$10.92	$9.28	$10.92	$10.92	$10.92	$10.92	$10.92	$9.28	$9.28	$9.28	$10.92	$10.92
A4258		$17.21	$14.63	$17.21	$17.21	$17.21	$17.21	$17.21	$17.21	$17.21	$17.21	$17.21	$17.21
A4259		$12.15	$10.33	$12.15	$10.33	$10.33	$10.33	$10.33	$12.15	$12.15	$10.33	$10.33	$10.33
A4265		$3.23	$2.75	$3.23	$3.23	$3.23	$3.23	$3.23	$3.23	$3.23	$3.23	$3.23	$3.23
A4556		$11.58	$9.84	$11.58	$11.58	$9.84	$9.84	$9.84	$11.58	$11.58	$9.84	$11.58	$9.84
A4557		$20.13	$17.11	$20.13	$17.11	$20.13	$20.13	$20.13	$17.11	$18.19	$17.11	$20.13	$20.13
A4558		$5.20	$4.42	$5.20	$4.42	$4.42	$4.42	$4.42	$5.20	$4.42	$4.42	$5.20	$4.42
A4595		$27.48	$23.36	$27.48	$27.48	$27.48	$27.48	$27.48	$27.48	$27.48	$27.48	$27.48	$27.48
E1701		$10.12	$8.60	$8.60	$9.89	$9.89	$9.89	$9.89	$9.89	$10.12	$9.89	$9.89	$9.89
E1702		$21.52	$18.29	$18.29	$19.85	$21.52	$21.52	$21.52	$19.85	$21.52	$19.85	$21.52	$21.52
K0182		$0.37	$0.31	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37	$0.37
K0283		$0.33	$0.28	$0.33	$0.33	$0.33	$0.33	$0.33	$0.33	$0.33	$0.33	$0.33	$0.33
K0529		$2.62	$2.23	$2.62	$2.62	$2.62	$2.62	$2.62	$2.62	$2.62	$2.62	$2.62	$2.62

Surgical Dressings

HCPCS	Mod	Ceiling	Floor	CT	DE	MA	ME	NH	NJ	NY	PA	RI	VT
A4460		$1.14	$0.97	$0.97	$0.97	$0.97	$0.97	$0.97	$0.97	$0.97	$0.97	$0.97	$0.97
A4462		$3.13	$2.66	$3.13	$3.13	$3.13	$3.13	$3.13	$3.13	$3.13	$3.13	$3.13	$3.13
A6154		$13.71	$11.65	$13.71	$13.71	$13.71	$13.71	$13.71	$13.71	$13.71	$13.71	$13.71	$13.71
A6196		$7.01	$5.96	$7.01	$7.01	$7.01	$7.01	$7.01	$7.01	$7.01	$7.01	$7.01	$7.01
A6197		$15.68	$13.33	$15.68	$15.68	$15.68	$15.68	$15.68	$15.68	$15.68	$15.68	$15.68	$15.68
A6199		$5.04	$4.28	$5.04	$5.04	$5.04	$5.04	$5.04	$5.04	$5.04	$5.04	$5.04	$5.04
A6200		$9.06	$7.70	$9.06	$9.06	$9.06	$9.06	$9.06	$9.06	$9.06	$9.06	$9.06	$9.06
A6201		$19.84	$16.86	$19.84	$19.84	$19.84	$19.84	$19.84	$19.84	$19.84	$19.84	$19.84	$19.84
A6202		$33.27	$28.28	$33.27	$33.27	$33.27	$33.27	$33.27	$33.27	$33.27	$33.27	$33.27	$33.27
A6203		$3.19	$2.71	$3.19	$3.19	$3.19	$3.19	$3.19	$3.19	$3.19	$3.19	$3.19	$3.19
A6204		$5.94	$5.05	$5.94	$5.94	$5.94	$5.94	$5.94	$5.94	$5.94	$5.94	$5.94	$5.94
A6207		$7.00	$5.95	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00	$7.00
A6209		$7.14	$6.07	$7.14	$7.14	$7.14	$7.14	$7.14	$7.14	$7.14	$7.14	$7.14	$7.14
A6210		$19.00	$16.15	$19.00	$19.00	$19.00	$19.00	$19.00	$19.00	$19.00	$19.00	$19.00	$19.00
A6211		$28.01	$23.81	$28.01	$28.01	$28.01	$28.01	$28.01	$28.01	$28.01	$28.01	$28.01	$28.01
A6212		$9.25	$7.86	$9.25	$9.25	$9.25	$9.25	$9.25	$9.25	$9.25	$9.25	$9.25	$9.25

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Bulletins issued after October 1, 1999 are available at no cost from our website at www.medicare-link.com.

Millennium Rollover Year-End Claims Processing

Supplier Notice 99-42
December 30, 1999

Electronic Billers: Please be aware that although you will not have access to claim status inquiry functions (e.g., eligibility verification, claims inquiry) between 6:00 P.M. (ST) December 28, 1999 and 9:00 A.M. on January 1, 2000, you can continue to submit claims electronically via the Bulletin Board System during that time. You can also continue to retrieve Claim Reject Reports on business days during that time period.

Please refer to the *DMERC Medicare News*, December 1999, number 48, for more information about Millennium Rollover Year-End Claims Processing.

Enteral Nutrient and Feeding Pump Billing Recommendations

Supplier Notice 2000-01
January 6, 2000

The Enteral Nutrition Policy states "If a pump is ordered, there must be documentation accompanying the CMN to justify its use (e.g., gravity feeding is not satisfactory due to reflux and or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, jejunostomy tube used for feeding)."

The examples indicate some scenarios when the medical necessity of the pump may be eligible for payment. To avoid denials:

- provide the precise rate of administration as described in the patient's medical record when the justification for the enteral pump is due to "administration rate less than 100 ml/hr"
- provide the results of glucose testing and the dates the tests were performed for the 90 day period preceding the initial date of service when justification for the enteral pump is due to "fluctuating blood sugars."
- provide the results of glucose testing and the dates the tests were performed for the 90 day period preceding the initial date of service when submitting documentation for disease-specific enteral nutrients to justify the need for the enteral pump is due to "fluctuating blood sugars" or "unstable blood sugars."

Oxygen Equipment CMN – Section B

Supplier Notice 2000-02
January 20, 2000

Section B of the Oxygen Equipment CMN (HCFA 484.2 Form) contains questions that relate to the patient's medical condition and the equipment being prescribed. All questions in Section B must be answered unless the question does not apply to the patient's condition. Questions that fall under this stipulation are questions 8 through 10 for Group I oxygen patients and question 7 for patients who are using their oxygen up to four lpm.

If the information does not apply to the patient and questions 7 though 10 are left blank by the physician, when submitting a claim electronically, the supplier may enter a "D" in the electronic version of the CMN.

Under no circumstances should a supplier make or modify any entries in Section B on the original paper CMN.

This policy is effective for all CMNs with dates of service on or after January 17, 2000.

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff.
Bulletins issued after October 1, 1999 are available at no cost from our website at www.medicare-link.com.

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