DMERC Medicare News

DMERC Region A Service Office • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800 • Phone (570) 735-9445 • www.medicare-link.com
Number 55 • September 2000 Edition

Written Statements of Intent (SOI) to Claim Medicare Benefits

This policy is effective for claims filing period ending December 31, 2000 (i.e., for services furnished from October 1, 1998 through September 30, 1999 and is extended through January 2, 2001 because December 31, 2000 is a federal non-workday).

Purpose of Statement of Intent

The purpose of a SOI is to extend the timely filing period for the submission of an initial claim. A SOI, by itself, does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. Medicare regulations at 42 CFR §§424.32 and 424.44 require that Medicare claims be filed on Medicare designated claim forms pursuant to Medicare instructions by the end of the year following the year in which the service(s) are furnished (services furnished in the last 3 months of a calendar year are deemed to be furnished in the subsequent year). The timely filing period to file a specific Medicare claim may be extended when a valid SOI, with respect to that claim, is furnished to the appropriate Medicare carrier or intermediary (i.e., the one that will be responsible for processing the claim), or regional office (RO) serving the area of the beneficiary's residence within the timely filing period. (If a RO receives a SOI, it should date stamp the SOI and forward it to the appropriate Medicare contractor.)

A SOI to claim Medicare benefits must be postmarked on or before, or received by the appropriate RO or contractor, no later than the last day of the timely filing period that pertains to the service(s) covered by the SOI. (See §3305.3 of the MIM.) If someone wishes to simultaneously submit more than one SOI to a RO, then he or she must sort them by Medicare contractor before submitting them. If a SOI contains the necessary information for some services, but not for others, then the SOI will be accepted only for those services for which the necessary information has been submitted.

After a valid SOI has been filed, a completed claim that meets the requirements of 42 CFR §424.32(a), §§3005- 3005.4 of the MCM, and §§3605.2-3605.3 of the MIM, must be submitted to the appropriate Medicare contractor within 6 months after the month in which the contractor notifies the party who submitted the SOI that a claim may be filed, or by the end of the applicable timely filing period, whichever is later. **(The month in which the contractor notifies the party is determined by the date of the contractor's notification letter, unless the recipient of the notice can establish by a preponderance of the evidence that the notice was sent on a materially different date. Also, "party" and "parties" are used herein in their generic sense, and are not meant to imply that an individual or entity that submits a SOI to file has standing to file a claim or pursue an appeal of a denied claim.**) In order to ensure that a filed claim, which is purportedly has been protected by a previously submitted SOI (and, which would be untimely if not so protected), does in fact relate back to the SOI, a SOI must be for an "identified beneficiary" and for "specified services." (See 42 CFR §424.45(b).)

(continued on page 3)

HCFA Health Care Financing Administration

UNITEDhealthcare®

In This Issue

Internet Address

Region A DMERC Office www.medicare-link.com
HCFA Office www.hcfa.gov

DMERC Region A Contacts

United HealthCare Region A DMERC	(570) 735-9400	Hearings Voice Mail	(570) 735-9513
United HealthCare Region A DMERC Fax	(570) 735-9402	Medicare Secondary Payer (MSP)	(570) 740-9001
Accounting	(570) 740-9002	National Supplier Clearinghouse	(803) 754-3951
Accounting / MSP Fax	(570) 735-9594	Professional Relations Fax	(570) 735-9442
Beneficiary Help Line	(570) 735-7383	Professional Relations	(570) 735-9666
Beneficiary Toll Free Help Line	(800) 842-2052	Program Integrity Toll Free Line	(888) 697-7849
EDI Fax	(570) 735-9510	Reconsiderations Fax	(570) 735-9599
EDI Help Desk	(570) 735-9429	SADMERC	(803) 736-6809
Hearings Fax	(570) 735-9422	Supplier Help Line	(570) 735-9445

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.

(*continued from page 1)*

Note: The filing of an invalid SOI does not extend the timely filing period, so that if a party submits an invalid SOI prior to the end of the timely filing period, and the contractor or the RO does not discover the invalidity and alert the submitter of the invalidity until shortly before, or even after the timely filing period has expired, the party may not correct or resubmit the SOI after the timely filing period has expired. In this regard, a party that submits an invalid SOI bears the full risk that he or she may be unable to resubmit a valid SOI within the applicable timely filing period.

Medicare contractors are not required to develop a claim under the SOI procedures. All claims for services must meet Medicare's timely filing requirements. (See 42 CFR §424.44.) Timely filing requirements are further discussed in §3004 of the MCM and in §§3307-3312.5 of the MIM.

Who Can Submit Statements of Intent

Only the following parties may submit a SOI to claim Medicare benefits:

- Providers, as defined in 42 CFR §400.202, and parties to whom they may assign their payment per 42 CFR §424.73, for items or services they have furnished or are entitled to bill Medicare.
- Suppliers, as defined in 42 CFR §400.202, and parties to whom they can reassign payment per 42 CFR §424.80, for items or services they have furnished or are entitled to bill Medicare.
- Medicaid State agencies and parties authorized to act on behalf of Medicaid State agencies, with respect to items and services rendered to dually eligible beneficiaries.
- Beneficiaries and their authorized representatives, but only where the SOI relates to (1) a claim for services furnished by a nonparticipating hospital that has elected not to claim payment for emergency services, or (2) a claim for services for which a physician or other supplier, or proper resignee, was required to file a claim under §1848(g)(4) of the Act but has not done so.

Contents of a Valid Statement of Intent

A SOI must be signed, and the person signing must indicated the capacity in which he or she is signing (e.g., beneficiary or beneficiary's authorized representative, provider, supplier, Medicaid State agency official, or party authorized to act on behalf of the Medicaid State agency).

For a SOI to be considered valid, it must be submitted to the appropriate contractor, and if a provider or supplier (or the party to whom payment can be assigned), or Medicaid State agency (or a party authorized to act on its behalf) submits a SOI, then the following information must be submitted with the SOI:

- Beneficiary name;
- Medicare Health Insurance Claim (HIC) number;
- Name, address, and Medicare billing number of provider/physician/supplier at time of service;
- Dates of service for which a specific claim will be filed (dates must be reported in a manner that comports with the Medicare claims filing instructions; range of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form); and,

- Applicable revenue, DRG, CPT, HCPCS or other applicable code, and appropriate modifiers for each service. (Codes must be reported in a manner consistent with the reporting of the codes on the Medicare claim form. Diagnosis codes by themselves are not acceptable.)

In order for a SOI that is submitted to a RO to be valid, the SOI must include all of the above information, and must also include the correct name and address of the Medicare contractor that will be responsible for processing the subsequent claim or claims.

If a beneficiary or authorized representative submits a SOI, it must be submitted to the appropriate contractor and must include all of the information listed below.

- Beneficiary name;
- Medicare Health Insurance Claim (HIC) number;
- Name, address, and if available, the Medicare billing number of the provider / physician / supplier at time of service;
- Date(s) of service for which a specific claim will be filed (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim); and,
- Item(s) or service(s) received.

In order for a SOI that is submitted to a RO by a beneficiary or a beneficiary's authorized representative to be valid, it must include the information listed above and also must include the name and address of the Medicare contractor that will be responsible for processing the subsequent claim or claims.

Submitters may obtain the name and address of the appropriate Medicare contractor (i.e., Medicare carrier or fiscal intermediary) at the following website:

http://www.medicare.gov/contacts/contact1.asp

Claims Processing Instructions for Claims Submitted With a Written Statement of Intent

Effective October 1, 2000, the Health Care Financing Administration (HCFA) has provided instructions to intermediaries and carriers on processing claims where a statement of intent (SOI) was used to extend the timely filing period for submission of claims. This is effective for the claims filing period ending December 31, 2000.

Part I, General Instructions to Intermediaries and Carriers on Receiving and Processing the SOI

Processing the SOI

The SOI should arrive at the appropriate Medicare contractor or be forwarded to the correct Medicare contractor from the appropriate HCFA regional office. It is the submitter's responsibility to submit the SOI to the appropriate Medicare contractor. If a contractor receives an SOI which should have been submitted to a different contractor, then that contractor should return the SOI to the submitter with instructions that they must forward the SOI to the appropriate contractor.

Contractors must return a letter of acknowledgment to the submitting entity, (provider, supplier, Medicaid State Agency, or entity acting on behalf of the Medicaid State Agency, or beneficiary) upon receipt of a valid or invalid SOI (according to PM AB-00-43). Examples of letters can be found in PM AB-99-100. Before sending out the acknowledgment letter, the contractor will search history to assure that a claim has not previously been submitted for these services.

The proper claimant then has six months after the month in which the acknowledgment letter for a valid SOI is issued to submit a claim to Medicare (42 CFR 424.45(c)). Contractors are not required to develop a claim from the submitted SOI. Contractors will not solicit the submis-

sion of claims from entities that have submitted SOIs.

Contractors must keep the SOI for a minimum of six months after the month of acknowledgment of the claim, in order to match the SOI with incoming claims. Contractors must be able to match the statement of intent with the claim.

Part II, Processing of Claims Submitted Beyond the Filing Deadline

Within six months after the month of the SOI acknowledgment letter, a valid claim form (either electronic or hardcopy) must be submitted in accordance with Medicare claims standards. When the claim denies for dates of service beyond the timely filing deadline, contractors must develop a way to determine if an SOI exists for this claim.

When a claim is submitted beyond the filing deadline, the contractor will verify that the six-month acknowledgment letter time limit has not expired.

If more than six months have passed after the month of the SOI acknowledgment letter, the claim will be denied.

If less than six months have passed, the contractor will verify that a valid SOI exists. If a valid SOI does not exist, the claim will be denied.

If the information on the claim does not match the information on the SOI, the claim will be denied.

If the SOI was filed correctly and the claim is submitted timely (within six months after the month of the acknowledgment letter), the contractor will process the claim as usual, according to the claims processing sections of the Medicare Intermediary Manual and Medicare Carriers Manual.

All SOI requests for the Region A DMERC should be sent to the attention of Beth Chabala.

SOI requests for the claim filing period ending December 31, 2000 must be received by January 2, 2001.

Special Coding Instructions

Some Medicare contractors have already developed internal systems to handle the function of matching an SOI with a claim.

To facilitate this process:

- Effective October 1, 2000, modifier **QQ** has been approved for providers/suppliers to place on the claim at the line level. This modifier is defined as "service for which a statement of intent was submitted, deemed as valid, and an acknowledgment letter was received." The claim will bypass any late filing auto denials for services with this modifier, and the contractor will compare the services on the statement of intent with the services on the claim. If the services do not match, the contractor will deny the service.
- Effective October 1, 2000, condition code **H0** (zero) has been approved by the National Uniform Billing Committee to facilitate this process. When a claim comes in with this condition code, this signals to the system that an SOI exists for this claim before the claim is rejected for timely filing. The claim will suspend thus allowing the contractor to verify that an SOI exists for this claim. It is the contractor's responsibility to determine if the SOI matches the information on the claim. If the SOI does not match the information/service on the claim, or an SOI cannot be found, the claim will be denied. If the SOI and the claim match, the claim will process as usual.

On the SOI acknowledgment letter, the submitter will be informed of the proper modifier or condition code. If the submitter of the SOI is not the provider/supplier who will be submitting the claim, they must instruct the provider/supplier to place one of these codes on the claim.

Billing

Seatlift Mechanisms

A seatlift mechanism is covered if all of the following criteria is met:

1. The patient must have severe arthritis of the hip or knee, or have a severe neuromuscular disease.

2. The seatlift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, arrest, or retard deterioration in the patient's condition.

3. The patient must be completely incapable of standing up from a regular armchair or any chair in their home.

4. The fact that a patient has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seatlift mechanism. Almost all patients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.

5. Once standing, the patient must have the ability to ambulate.

The physician ordering the seatlift mechanism must be the attending physician or a consulting physician for the disease or condition resulting in a need for a seatlift. The physician's record must document that all appropriate therapeutic modalities have been tried and failed to enable the patient to transfer from a chair to a standing position.

An order for a seatlift mechanism, signed and dated by the physician, must be received by the supplier prior to the delivery of the item. A CMN completed, signed, and dated by the ordering physician may be substituted for the order if returned to the supplier prior to delivery. Otherwise, the prior completed order and subsequent CMN must be kept on file by the supplier.

Please reference the *Region A Durable Medical Equipment Supplier Manual* Policy Section 14.5 Seatlift Mechanisms for any additional information.

Oxygen Modifiers

For dates of service on or after January 1, 2001, all oxygen claims submitted to Region A DMERC must have the correct modifiers included with the HCPCS Codes.

The revised Oxygen policy (effective July 1, 2000) states "The appropriate modifier must be used if the prescribed flow rate is less than 1LPM (QE) or greater than 4LPM (QF or QG)."

Modifiers Required:

QE Prescribed amount of oxygen is **less** than 1 liter per minute (LPM).

QF Prescribed amount of oxygen is **greater** than 4 liters per minute (LPM) and *portable oxygen is also prescribed.*

QG Prescribed amount of oxygen is **greater** than 4 liters per minute (LPM) and *portable oxygen is not prescribed.*

QH Oxygen conserving device is being used with oxygen delivery system.

For all claims submitted with dates of service on or after January 1, 2001, *the correct modifier must be used on oxygen codes.* Claims submitted without a modifier or an incorrect modifier will be denied. This denial *will not* have appeal rights. A new claim submission will be required.

Breathing Circuits – Billing Instructions

Code A4618 describes the breathing circuit used with a volume ventilator (E0450) (see below). A breathing circuit is a series of hoses and connectors that deliver the "breath" generated by the ventilator to the patient. Breathing circuits are not used with oxygen equipment or nebulizers, therefore, do not bill code A4618 as an accessory used with these devices.

While code A4618 describes a breathing circuit for use with a ventilator, it is not separately reimbursable since code E0450 is in the frequently serviced items payment category. Claims for A4618, when billed with an E0450, will be denied as not separately payable.

Medical Policy

Oxygen Enriching Systems (E1405, E1406)

Codes E1405 and E1406 describe oxygen and water vapor enriching systems with or without heated delivery, respectively. The revised oxygen policy and a newsletter article published in June 2000 stated that these codes were no longer valid for claim submission to the DMERC. That decision is rescinded. Codes E1405 and E1406 may continue to be submitted–but only for products for which a written coding determination dated on or after July 1, 2000 specifying use of these codes has been made by the DMERC. At the present time, the only product that may be billed using code E1405 or E1406 is the Oxygen Enricher manufactured by the Oxygen Enrichment Company (OECO). If a manufacturer or supplier has a different device that they believe qualifies for coding as E1405 or E1406, they should contact the SADMERC for a written coding determination. Effective for claims with dates of service on or after December 1, 2000, all claims for E1405 or E1406 must be accompanied by the manufacturer's name and product name of the item provided. This information should be entered in the HA0 record of an electronic claim or attached to a hard copy claim.

Tracheostoma Filters

HCPCS Code A4481 (Tracheostoma filter, any type, any size, each) describes a soft foam filter designed to provide air filtration for the tracheal stoma. In a recent publication (*DMERC Medicare News*, December 1998), a "usual maximum" guideline of one A4481 per day was published. Effective for dates of service on or after October 1, 2000, this "usual maximum" parameter will be removed.

Suppliers are reminded that there should be documentation in the patient's medical record supporting the number of filters ordered. 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, including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists. This information does not have to be routinely sent to the DMERC, but must be made available to the DMERC upon request.

New Policy on Negative Pressure Wound Therapy

A new regional medical review policy on Negative Pressure Wound Therapy (NPWT) is being published in the accompanying *Region A DMERC Supplier Manual* revision. The policy is effective for dates of service on or after October 1, 2000.

Flolan (Epoprostenol) – J1325

A revision of the External Infusion Pumps policy is included in the accompanying *Region A DMERC Supplier Manual* revision. The only revision is in the coverage criteria for epoprostenol (Flolan). The revised criteria represent an expansion of the current published criteria, and therefore, are effective for claims with dates of service on or after October 1, 2000.

Osteogenesis Stimulators

A revision to the Osteogenesis Stimulators policy is published in the accompanying *Region A DMERC Supplier Manual* revision. The description of a fracture nonunion is being clarified by indicating that the required radiographs must show no clinically significant healing. An article in the March 2000 *Region A DMERC Medicare News* stated that until the wording of question 6a on the Osteogenesis Stimulators CMN is revised to more clearly describe the new definition of a fracture nonunion, suppliers must attach a specific statement to each CMN that is sent to the physician. This statement is revised to say: "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 clinically significant evidence of fracture healing between the two sets of radiographs. If this definition of nonunion is not met, question 6a must be answered No."

Immunosuppressive Drugs – DMERC Information Form

A revision of the Immunosuppressive Drugs policy is included in the accompanying *Region A DMERC Supplier Manual* revision. The DMERC Information Form (DIF) is revised to include additional possible responses to question #5, which asks to identify the organ that was transplanted. The new responses include (6) Whole organ pancreas, simultaneous with or subsequent to a kidney transplant and (9) Other. If response (9) is given, the name of the organ transplanted must be entered in the HA0 record of an electronic claim or attached to a hard copy claim. The Documentation section of the policy was revised by eliminating one paragraph that related to the use of the prior DIF.

There is a six-month "grace period" for the use of the new DIF. Suppliers may use either the old or new DIF for claims received on or after October 1, 2000; however, use of the new DIF will be required for claims received on or after April 1, 2001. Refer to the Immunosuppressive Drugs policy for additional information on Coverage and Payment Rules, Coding Guidelines, and Documentation.

Batteries for Power Wheelchairs and POVs

Effective for dates of service on or after October 1, 2000, the DMERC medical policy on Wheelchair Options and Accessories will be revised to allow payment for gel cell and/or Group 24 batteries for power wheelchairs if they are ordered by a physician and are reasonable considering the patient's use of the wheelchair. The paragraph in the Coverage and Payment Rules section of the policy concerning batteries will be revised to say:

"Up to two batteries (K0082-K0087) at any one time are allowed if required for a power wheelchair. A battery is separately payable from the wheelchair base."

Any type battery will also be covered if it is provided as a replacement in a POV, is ordered by a physician, and is reasonable considering the patient's use of the POV. When provided as a replacement in a POV, batteries are coded E1399, and the claim must include a description of the type of battery provided. Batteries are included in the allowance for a POV and must not be billed separately with the initial issue of a POV.

HCPCS

New NDC Numbers for Methotrexate and Cyclophosphamide

Suppliers are currently instructed to bill oral anticancer drugs to the DMERCs using the appropriate National Drug Code (NDC) number.

Five additional NDC numbers have been added for methotrexate products:

Methotrexate, 2.5 mg, oral	(NDC #00005-4507-04)
Methotrexate, 2.5 mg, oral	(NDC #00005-4507-05)
Methotrexate, 2.5 mg, oral	(NDC #00005-4507-07)
Methotrexate, 2.5 mg, oral	(NDC #00005-4507-09)
Methotrexate, 2.5 mg, oral	(NDC #00005-4507-91)

Two additional NDC numbers have been added for cyclophosphamide products:

Cyclophosphamide, 25 mg, oral	(NDC #00054-4129-25)
Cyclophosphamide, 50 mg, oral	(NDC #00054-4130-25)

These numbers are valid for claims with dates of service on or after October 1, 2000.

Professional Relations

Fall 2000 Continuing Education Workshops

Region A DMERC announces the Fall 2000 continuing education workshops. The topics for the workshops are: Mobility, Parenteral & Enteral Nutrition, and EDI/HIPAA. Each session will also include updates from Region A, noting recent changes affecting DMERC Medicare policy. During these sessions, suppliers will have the opportunity to receive information and instruction on each topic. ***Stay tuned for additional information regarding workshop dates, locations, and registration***.

Appeals Analysis: HCPCS Code E0260

The Region A DMERC has recently completed its analysis of claims appealed and overturned for the third quarter of Fiscal Year 2000. Through this research, the DMERC has noted that a large volume of previously denied claims submitted for semi-electric hospital beds, HCPCS code E0260, have been overturned through appeal. It has been identified that initial denials resulted due to a lack of required documentation.

HCPCS code E0260 is described as a hospital bed, semi-electric (head and foot adjustment), with any type of side rails, with mattress. Chapter 14.15 of the *Region A DMERC Supplier Manual* provides instruction to suppliers regarding coverage and payment for these items of DME. "If the documentation does not support the medical necessity of a semi-electric bed, but does support the necessity of a lower level bed, the payment will be based on the allowance for the least costly alternative." (p. 14.15-2)

Additionally, please be sure to attach the proper modifier when submitting claims for HCPCS E0260, a capped rental item. Modifiers applicable to monthly billing for hospital beds and other capped rental items include:

KH DMEPOS item, initial claim, purchase or capped rental,

KI DMEPOS item, second or third month rental,

KJ DMEPOS item, parenteral enteral nutrition pump (PEN) or capped rental, months four to fifteen.

Please note that additional modifiers are required by the DMERC in order to accurately record the beneficiary's election to purchase or continue renting the item. These are denoted as **BP**, **BR** and **BU**.

Region A urges all suppliers to review Chapter 5.3, Modifiers, in the *Region A DMERC Supplier Manual* for thorough instruction on the usage of modifiers. Additionally, you may choose to review Supplier Notices 98-16 and 98-22 for additional information on modifiers. Please note, each of the above references is available through our web site, www.medicare-link.com.

Contractor Updating of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Beginning October 1, 2000, providers may begin using the updated ICD-9-CM codes for claims submitted on or after October 1; the updated diagnostic codes must be used for professional services billed on or after January 1, 2001.

The DMERC is required to accept both old and new ICD-9-CM codes for claims received October 1 through December 31, 2000. This grace period gives providers sufficient time to obtain and integrate the latest version of the ICD-9-CM codes into their billing system. It is important for providers to use the most recent version of the ICD-9-CM coding book and to code to the highest level of specificity.

ICD-9-CM books can be obtained from:

American Medical Association	1-800-621-8335
Channel Publishing	1-800-248-2882
Medicode	1-800-999-4600
Any medical bookstore	

Announcements from the Professional Relations Unit

Please join us in welcoming the new team members of the Professional Relations Unit.

The Professional Relations Unit is pleased to announce the following new appointments:

Laurie Kulak has assumed the responsibilities of Ombudsman for the states of Maine, New Hampshire, Rhode Island, and Vermont. Laurie's Product / Process Focus Group (P / PFG) is the Respiratory category. Laurie has six years of experience as a Respiratory Care Practitioner along with experience in training, implementing policy and procedure, and utilization.

Mary Jo George Rouè has replaced David Fiorini as the Ombudsman for the states of Connecticut and Massachusetts. Mary Jo's P / PFG category is the Orthotics and Prosthetics category. Mary Jo has an extensive background in health services administration, holding various positions in the healthcare industry. Mary Jo's experience includes being responsible for agency and provider relations offering healthcare-related education and administration of various programs.

David Fiorini has assumed the position of Beneficiary Ombudsman for Region A; his state territory will be announced at a later date.

Jean Gober has replaced Paul Komishock as the Ombudsman for the states of Delaware and New Jersey. Jean's P / PFG category is the Specialized DME category. Jean has been associated with the DMERC for one year as a Customer Service Representative in Provider Services. Jean also has a history of experience in the health care industry, including billing for physician services and providing onsite education in diagnostic laboratory testing.

Marion Gaynor will assume the position of the DMERC Congressional Liaison. Marion has been associated with the DMERC for seven years primarily in the Correspondence Unit. The effective date for Marion's new position has yet to be determined.

DMERCs to Attend Medtrade Show

The four Durable Medical Equipment Regional Carriers (DMERCs) will attend the Medtrade 2000 Exposition and Conference being held October 3–5, 2000 in Orlando, Florida. All four Regions will again share booth space and present at the DMERC Vendor Conference on October 5, 2000. This joint effort by the DMERCs gives the supplier community an opportunity to interact with all four DMERCs in one location. Please visit the DMERCs at booth 3854.

SADMERC

These articles were submitted by the SADMERC. Any questions regarding these articles should be directed to the SADMERC.

Differences in Fee Schedule and Non-Fee Schedule Items

The Statistical Analysis Durable Medical Regional Carrier's (SADMERC) primary responsibility is to assist suppliers with coding requests for the four Durable Medical Equipment Regional Carriers (DMERC). SADMERC also provides suppliers with Medicare allowances for codes in the DMEPOS Fee Schedule.

The SADMERC cannot answer pricing questions for codes that are individually considered, priced by reasonable charge, or which have no fee schedule amount established. Examples of non-fee schedule items include:

- Drugs
- Therapeutic Shoes for Diabetics
- Enteral and Parenteral Nutrition
- Miscellaneous Codes (E1399, L2999, L3999, K0108 etc.)

Requestors of pricing for non-fee schedule codes will be referred to their DMERC for pricing information.

SADMERC Website Training

The SADMERC added a new tutorial to their website. This instruction provides the user with information about the SADMERC. It will guide suppliers, the DMERCs, and any other HCPCS code users on the functions of the SADMERC. Please visit the SADMERC at the following address:

http://www.pgba.com./palmetto/main.nsf/allframesets/oth_sadm.html

Supplier Notices

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

Correction: Coding of Clinitron Beds

Supplier Notice 2000-20
June 12, 2000

The correct HCPCs code for billing the Clinitron At-Home and the Clinitron Elexis is E0194. Since September 1999, the DMERC has published these products within the Group II Support Surface Classification List in the Appendices section of the *Region A DMERC Supplier Manual* as E0193.

Please note: The E0194 is a Group III Support Surface; the DMERC does not include Group III codes in the Appendices section of the supplier manual. The Appendices section of the June 2000 supplier manual revision #14 has been updated to reflect this correction. Please be sure to update your manuals when you receive this revision.

The DMERC apologizes for any inconvenience this may have caused.

Delay in Third Quarter Release

Supplier Notice 2000-21
June 30, 2000

Due to a HCFA delay, the CY 2000 third quarter Common Working File (CWF) and Medicare Claims Processing Standard Systems release is targeted for implementation on August 14, 2000. Because of the delay of the 3rd quarter release, we are advising suppliers of the following:

Oral Anticancer Drugs (June 2000 DME Medicare News, page 5) Update:

As previously published in the March 2000 newsletter, suppliers should continue to bill using the J8999 code for busulfan and temozolomide. Include the name of the drug, the NDC code, and the number dispensed in the HAO record of an electronic claim and attached to a hard copy claim.

Effective for claims received on or after August 14, 2000, suppliers should bill for these oral anticancer drugs using the instructions published on page five of the June 2000 *DMERC Medicare News.*

Year 2000 Fee Revisions for L2405, L2415, L2425 and L2430

Supplier Notice 2000-22
August 3, 2000

It was brought to our attention that the fee for code L2430 was established using the wholesale and not the retail price list. In examining this code we decided to review the other sequence of "Addition to knee joint" codes. The base fees for codes L2405, L2415 and L2425 were initially gap-filled by the previous local carriers. The result of this review increased base fees for codes L2405 and L2430. The current fees for codes L2415 and L2425 were found to actually reflect the cost of a pair of joints instead of per each joint, as described by the codes listed below. Therefore, the base fees for these two codes will decrease.

The Region A DMERC revised the year 2000 fees for all four codes for claims with dates of service January 1, 2000 and after that are processed on or after July 1, 2000. The revised fees for these codes were developed using available price lists.

L2405 Addition to knee joint, drop lock, each joint

L2415 Addition to knee joint, cam lock (Swiss, French, bail types) each joint.

L2425 Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint.

L2430 Addition to knee joint, ratchet lock for active and progressive knee extension, each joint

The chart below reflects the revised base fees including the final fees implemented on July 1, 2000.

Note: Inclusion or exclusion of an allowable amount for an item or service does not imply Medicare coverage.

Code	State	Current Base Fee	Revised Base Fee	Revised 2000 Fee
L2405	CT	$20.00	$54.94	$64.69
	DE	$29.69	$54.94	$64.69
	MA	$19.32	$54.94	$64.69
	ME	$19.63	$54.94	$64.69
	NH	$18.81	$54.94	$64.69
	NJ	$29.69	$54.94	$64.69
	NY	$36.25	$54.94	$64.69
	PA	$30.11	$54.94	$64.69
	RI	$19.53	$54.94	$64.69
	VT	$19.04	$54.94	$64.69
L2415	CT	$172.35	$76.55	$90.13
	DE	$130.72	$76.55	$90.13
	MA	$172.35	$76.55	$90.13
	ME	$172.35	$76.55	$90.13
	NH	$172.35	$76.55	$90.13
	NJ	$129.26	$76.55	$90.13
	NY	$129.26	$76.55	$90.13
	PA	$130.72	$76.55	$90.13
	RI	$172.35	$76.55	$90.13
	VT	$172.35	$76.55	$90.13
L2425	CT	$146.15	$90.33	$106.37
	DE	$159.94	$90.33	$106.37
	MA	$146.15	$90.33	$106.37
	ME	$146.15	$90.33	$106.37
	NH	$146.15	$90.33	$106.37
	NJ	$153.84	$90.33	$106.37
	NY	$153.84	$90.33	$106.37
	PA	$159.94	$90.33	$106.37
	RI	$146.15	$90.33	$106.37
	VT	$146.15	$90.33	$106.37
L2430	CT	$72.17	$86.30	$106.37
	DE	$72.20	$86.30	$106.37
	MA	$72.17	$86.30	$106.37
	ME	$72.17	$86.30	$106.37
	NH	$72.17	$86.30	$106.37
	NJ	$72.17	$86.30	$106.37
	NY	$72.17	$86.30	$106.37
	PA	$72.20	$86.30	$106.37
	RI	$72.17	$86.30	$106.37
	VT	$72.17	$86.30	$106.37

If you have any questions regarding these changes, please send them to:

United HealthCare Medicare Region A
Medicare Reimbursement
PO Box 6800
Wilkes-Barre, Pennsylvania 18773

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.

Facial Prosthesis Fee Schedule

Supplier Notice 2000-23
August 3, 2000

Listed below are year 2000 fee schedules for the facial prostheses codes. When a replacement prosthesis is fabricated starting with a new impression / moulage, use the KM modifier. When a replacement prosthesis is fabricated using a previous master model, use the KN modifier. When a replacement involves a new impression / moulage (KM) rather than use of a previous master model (KN), the reason for the new impression / moulage must be clearly documented in the supplier's records and be available to the DMERC on request. Please refer to your *Region A DMERC Supplier Manual*, Chapter 16, for the Facial Prostheses policy.

	K0440	K0441	K0442	K0443	K0444	K0445	K0446	K0447
CT	1584.77	1910.25	2146.34	2403.92	2661.46	1673.19	1717.08	879.99
DE	1509.26	1819.16	2044.01	2289.28	2534.56	1769.32	1635.20	838.06
MA	1584.77	1910.25	2146.34	2403.92	2661.46	1673.19	1717.08	879.99
ME	1584.77	1910.25	2146.34	2403.92	2661.46	1673.19	1717.08	879.99
NH	1584.77	1910.25	2146.34	2403.92	2661.46	1673.19	1717.08	879.99
NJ	1645.99	1983.94	2229.14	2496.64	2764.13	1737.57	1783.31	913.95
NY	1645.99	1983.94	2229.14	2496.64	2764.13	1737.57	1783.31	913.95
PA	1509.26	1819.16	2044.01	2289.28	2534.56	1769.32	1635.20	838.06
RI	1584.77	1910.25	2146.34	2403.92	2661.46	1673.19	1717.08	879.99
VT	1584.77	1910.25	2146.34	2403.92	2661.46	1673.19	1717.08	879.99

	K0440KM	K0441KM	K0442KM	K0443KM	K0444KM	K0445KM	K0446KM	K0447KM
CT	1505.53	1814.73	2039.03	2283.71	2528.39	1589.53	1631.22	836.00
DE	1433.81	1728.19	1941.81	2174.81	2407.82	1680.86	1553.45	796.13
MA	1505.53	1814.73	2039.03	2283.71	2528.39	1589.53	1631.22	836.00
ME	1505.53	1814.73	2039.03	2283.71	2528.39	1589.53	1631.22	836.00
NH	1505.53	1814.73	2039.03	2283.71	2528.39	1589.53	1631.22	836.00
NJ	1563.68	1884.75	2117.69	2371.81	2625.94	1650.69	1694.15	868.26
NY	1563.68	1884.75	2117.69	2371.81	2625.94	1650.69	1694.15	868.26
PA	1433.81	1728.19	1941.81	2174.81	2407.82	1680.86	1553.45	796.13
RI	1505.53	1814.73	2039.03	2283.71	2528.39	1589.53	1631.22	836.00
VT	1505.53	1814.73	2039.03	2283.71	2528.39	1589.53	1631.22	836.00

	K0440KN	K0441KN	K0442KN	K0443KN	K0444KN	K0445KN	K0446KN	K0447KN
CT	633.90	764.11	858.54	961.56	1064.58	669.29	686.83	352.01
DE	603.71	727.66	817.58	915.72	1013.83	707.73	654.09	335.22
MA	633.90	764.11	858.54	961.56	1064.58	669.29	686.83	352.01
ME	633.90	764.11	858.54	961.56	1064.58	669.29	686.83	352.01
NH	633.90	764.11	858.54	961.56	1064.58	669.29	686.83	352.01
NJ	658.40	793.57	891.65	998.65	1105.66	695.02	713.32	365.58
NY	658.40	793.57	891.65	998.65	1105.66	695.02	713.32	365.58
PA	603.71	727.66	817.58	915.72	1013.83	707.73	654.09	335.22
RI	633.90	764.11	858.54	961.56	1064.58	669.29	686.83	352.01
VT	633.90	764.11	858.54	961.56	1064.58	669.29	686.83	352.01

DMERC Medicare News

United HealthCare Insurance Company • P.O. Box 6800 • Wilkes-Barre, PA 18773-6800

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

Bulk Rate
U.S. POSTAGE
PAID
Hartford, Conn.
Permit No. 2320